

**SUMMARY PLAN DESCRIPTION /  
PLAN DOCUMENT**

**INSULATORS LOCAL 84 HEALTH CARE PLAN**



Revised October 2018

**SUMMARY PLAN DESCRIPTION/  
PLAN DOCUMENT  
EFFECTIVE OCTOBER 1, 2018**

**INSULATORS LOCAL 84 HEALTH CARE PLAN**

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## **INSULATORS LOCAL 84 HEALTH CARE PLAN**

October 2018

To All Health Plan Participants:

The Trustees of the Insulators Local 84 Health Plan (hereinafter “Health Plan” or “Plan”) are pleased to present you with this booklet. This booklet describes the Health Plan’s provisions and includes advisory information required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

We urge you to read this booklet carefully in order to become familiar with the Health Plan, which was established effective June 1, 2005. The Health Plan described in this booklet is for employees who are eligible to be covered under the Health Plan on or after October 1, 2018. If you have questions pertaining to your coverage under the Health Plan, your rights are determined in accordance with the terms of the plan document then in effect.

This Plan booklet reflects the changes to your Plan since you last received a Plan Document/Summary Plan Description. You have been advised of some changes to the previous Plan by receipt of various Summary Descriptions of Material Modification.

Only the full Board of Trustees is authorized to interpret the Health Plan. No other individual or organization, such as your union or employer, nor any employee or representative of any individual or organization, is authorized to interpret the Health Plan or to act as an agent of the Board of Trustees. Should you have any questions regarding the Health Plan, please direct them to the Plan’s Third Party Administrator.

We suggest that you share this booklet with the members of your family since they may have an interest in the Health Plan. You should keep this booklet with your other important papers and let your family members know where it is being kept.

**Sincerely,**

**THE BOARD OF TRUSTEES**

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## INTRODUCTION

This booklet, distributed in October 2018, is designed to describe the benefits available to you under the Insulators Local 84 Health Care Plan. It is intended that this information will satisfy the requirements of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), for a Summary Plan Description (hereinafter “Summary”). This booklet also constitutes the Plan Document (“Plan”), setting forth the terms and conditions of the Plan.

This Plan is maintained pursuant to the Collective Bargaining Agreement between the International Association of Heat and Frost Insulators and Allied Workers, Local Union No. 84 (hereinafter “Union” or “Local 84”) and the Master Insulators Association of Akron, Ohio and the Builders Association of Eastern Ohio and Western Pennsylvania (hereinafter collectively referred to as the “Association,”) and other Employers who, by virtue of collective bargaining agreements with the Union, have agreed to participate in the Health Plan and contribute to the Health Plan’s trust fund and who became parties thereto. A copy of the Collective Bargaining Agreement is available for your examination at the Union Hall, and Participants and their Beneficiaries may also obtain a copy of the Collective Bargaining Agreement for a reasonable charge by writing to the International Association of Heat and Frost Insulators and Allied Workers Local No. 84, 277 Martinel Drive, Kent, OH 44240.

## SPECIAL NOTICE!

It is extremely important you keep the Fund Office informed of any changes in address or marital status. This is your obligation, and failure to fulfill this obligation could jeopardize your eligibility for benefits.

The importance of maintaining a current, correct address on file in the Fund Office cannot be overstated! It is the **ONLY** way the Trustees can keep in touch with you regarding changes to the Plan and other developments affecting your interests under the Plan.

## **LOSS OF GRANDFATHERED STATUS**

Effective June 1, 2014, this group health plan was no longer be considered a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Because your plan is no longer grandfathered, your plan must include certain consumer protections of the Affordable Care Act, for example, the requirement for the provision of preventative health services without any cost sharing. The requirements for non-grandfathered plans under the Affordable Care Act have been incorporated herein, and it is the intent of the Plan to comply with all requirements for grandfathered plans under the Affordable Care Act beginning as of June 1, 2014.

**I. PLAN IDENTIFICATION AND GENERAL INFORMATION**

**A. Name of the Fund**

The formal name of the Health Plan is the “Insulators Local 84 Health Care Plan.”

**B. Names and Addresses of the Employers**

The Health Plan is a multiemployer plan as that term is defined under ERISA, and numerous Employers contribute to it. It would not be practical to list them all here; however, upon written request to the Health Plan’s Third Party Administrator, you will receive information as to whether a particular Employer or Union is contributing to the Health Plan, and if so, its address.

**C. Name and Address of the Plan Sponsor**

The Plan Sponsor of the Health Plan is the Board of Trustees of the Insulators Local 84 Health Care Plan. The name and address of the Plan Sponsor is as follows:

Board of Trustees  
Insulators Local 84 Health Care Plan  
33 Fitch Boulevard  
Austintown, OH 44515  
Phone: (330) 779-8884  
Fax: (330) 270-0912

**D. Name and Address of the Third Party Administrator**

The Health Plan shall be administered and maintained by the Board of Trustees; however, the Trustees have the authority to select and retain a professional Administrator, if and when the need arises. The Board of Trustees, exercising its authority to select and retain a professional Administrator, has presently engaged BeneSys, Inc. to administer the Health Plan. The name and address of the Third Party Administrator is as follows:

BeneSys, Inc.  
33 Fitch Boulevard  
Austintown, OH 44515  
Phone: (330) 779-8884  
Fax: (330) 270-0912

Questions pertaining to your eligibility or your Dependent’s eligibility under the Health Plan and claims processing should be directed to the Third Party Administrator. In addition, the Board of Trustees has presently engaged Medical Mutual of Ohio to process the claims of the Health Plan. Please refer to your insurance card for how to contact the claims administrator with questions.

**E. Plan Numbers Assigned to the Plan**

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 30-0224279, and the Plan number for purposes of identification is 501.

**F. Type of Plan**

The Health Plan is maintained for the purpose of providing benefits to Participants and their Eligible Dependents as provided herein only where accident, injury, illness or related illnesses are incurred when the Participant is otherwise eligible, as described in this Summary, for coverage under the Health Plan. In addition, the Health Plan provides reimbursement to Participants for medical expenses not covered under other health insurance programs and other benefits, including the opportunity for Participants to purchase group-term life insurance and to make self-payments from their Credit Accounts.

**G. The Plan Year**

The Plan Year is a twelve (12) month period beginning June 1 and ending May 31. Annual limits on deductibles, co-pay maximums, out-of-pocket expenses, and related limits are based on the Plan Year.

**H. Type of Administration Used for the Plan Assets**

The Trust Fund shall be administered by a Board of Trustees consisting of six (6) voting Trustees, three (3) of whom shall be designated by the Employers (Employer Trustees), and three (3) of whom shall be designated by the Union (Union Trustees). At the present time, they are:

**UNION TRUSTEES**

Richard Quintrell  
Jason Penix  
Todd Miller

**EMPLOYER TRUSTEES**

Kevin Reilly  
Marty Harrington

Correspondence can be sent to the Board of Trustees at: Trustees of the Insulators Local 84 Health Plan, 33 Fitch Boulevard, Austintown, Ohio 44515

**I. Attorneys for the Fund and Agent for Service of Process**

Allotta | Farley Co., L.P.A.  
2222 Centennial Road  
Toledo, Ohio 43617  
Phone: (419) 535-0075  
Fax: (419) 535-1935  
Website: [www.allottafarley.com](http://www.allottafarley.com)

**J. Funding Medium for the Accumulation of Plan Assets**

Assets are accumulated and benefits are provided directly by the Trust Fund. The principal and income of this Health Plan are to be used for the exclusive benefit of Participants and their Eligible Dependents, and for defraying proper expenses of administering the Health Plan.

**K. Effective Date When Health Plan Began**

June 1, 2005.

**L. Sources of Contributions to the Health Plan**

Contributions to the Health Plan are made by Employers together with self-contributions by Participants in accordance with the terms and conditions of the Health Plan and such other requirements as the Board of Trustees may determine. Contributions to the Health Plan made by Employers shall be made to the Trust Fund only under the obligations of a collective bargaining agreement and/or other written agreement between the contributing Employer and the Union. The Union shall be the authority for the specific provisions of the collective bargaining agreement establishing the obligation of the Employer to make contributions.

**M. Plan Amendment and Termination**

The Trustees reserve the right to amend or terminate the Health Plan at any time and for any reason. If the Health Plan is amended or terminated, you and other active and retired employees may not receive benefits as described in other sections of this Summary. You may be entitled to receive different benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, even after you retire, if the Trustees decide to terminate the Health Plan or your coverage under the Health Plan. In no event will you become entitled to any vested rights under this Health Plan. Further, the provisions of this paragraph cannot be modified in any manner except by resolution of the Board of Trustees.

**N. Plan is Not a Contract**

The Health Plan shall not be deemed to be a contract between the Plan Sponsor and any Participant and/or Beneficiary, or to be an inducement to or condition of employment. Nothing in the Health Plan shall be deemed to give an Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Employee at any time.

**II. ELIGIBILITY**

**A. Initial Eligibility**

You will become initially eligible for coverage under the Health Plan at 12:01 a.m. on the first day of the coverage month following the date on which contributions for at least three hundred and eighty-four (384) hours, at the rate established by the current collective bargaining agreement, were

required to be made on your behalf during three (3) consecutive calendar months by one or more participating Employers. For example, if a contributing Employer is required to pay total contributions on your behalf for three hundred and eighty-four (384) hours in December, January, and February, you would begin your coverage under the Health Plan on March 1. Please see the table below for further clarification.

<b><u>384 Hours of Contributions for These 3 Consecutive Months</u></b>	<b><u>Coverage Beginning This Month</u></b>
January, February and March	April
February, March and April	May
March, April and May	June
April, May and June	July
May, June and July	August
June, July and August	September
July, August, and September	October
August, September and October	November
September, October and November	December
October, November and December	January
November, December and January	February
December, January and February	March

In no event may any person become initially eligible for coverage under the Health Plan if he or she is receiving a pension benefit from either the National Asbestos Workers Pension Fund or the Local #84 Asbestos Workers Pension Fund.

**B. Continuation of Eligibility**

**1. General Rule of Continuation of Eligibility**

After satisfying the initial eligibility requirements, you will continue to remain eligible for participation in the Plan so long as contributions are made on your behalf by an Employer and/or Reserve Hours are applied for one hundred thirty-six (136) hours per month at the hourly rate established in the current collective bargaining agreement. For example, once you become eligible, you will remain eligible if you meet the minimum working requirements set forth in the following schedule:

<u>Work Month</u>	<u>Minimum Number of Hours Required in the Following Months</u>	<u>Month Participant is Eligible for Benefits</u>
APRIL	136 HOURS	JULY
MAY	136 HOURS	AUGUST
JUNE	136 HOURS	SEPTEMBER
JULY	136 HOURS	OCTOBER
AUGUST	136 HOURS	NOVEMBER
SEPTEMBER	136 HOURS	DECEMBER
OCTOBER	136 HOURS	JANUARY
NOVEMBER	136 HOURS	FEBRUARY

DECEMBER	136 HOURS	MARCH
JANUARY	136 HOURS	APRIL
FEBRUARY	136 HOURS	MAY
MARCH	136 HOURS	JUNE

If, after expending all unused Reserve Hours, you have fewer than one hundred thirty-six (136) hours in any calendar month, you may make a self-contribution at the hourly rate established in the current collective bargaining agreement to remain eligible for participation in the Plan in an amount not to exceed the current self-pay contribution rate for Retired Employees under Article IV. The maximum number of self-contributions that an active Employee may make is eighteen (18) consecutive self-contributions in the full amount required under the Collective Bargaining Agreement.

Self-contributions must be received by the Fund Office not later than the 10<sup>th</sup> day of each month. Failure to make a timely self-contribution payment or making payment in less than the invoiced amount shall result in a loss of eligibility. However, if you lose your Union membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws, then immediately as of the date of the loss of Union membership and upon notification to the Fund Office you will not be eligible to make self-contributions pursuant to this Section, and you shall forfeit all unused Reserve Hours. Thereafter, you may elect to continue your health coverage under the Plan as provided for under Article II, Sections N and O below.

**2. Continuation of Eligibility While Working for Delinquent Employer**

A Participant who is employed by a contributing Employer may be granted up to three (3) work months of credit toward remaining eligible as a Participant in the Fund to receive benefits if the contributing employer has not paid its required contributions to the Fund and filed the appropriate Employer reports.

If an Employer is delinquent for three (3) work months, consecutive or nonconsecutive, of contributions to the Fund, whether the delinquency is for a full or partial work month, an employee of that Employer will no longer receive credit allowing the employee to maintain his/her eligibility.

Prior to the employee no longer receiving credit, the Trustees or their designee shall notify the employee at least fifteen (15) days prior to the fifteenth day of the month in which the employee will no longer receive credit.

Once the employee is no longer granted credit, the employee may continue to maintain his/her eligibility in the Fund by using his/her reserve dollar bank or making self-payments for a period of time not to exceed twelve (12) months from the date the first self-payment is made.

An employee will lose eligibility and receive the option to elect to continue his/her health coverage under the Plan as provided under Article II, Sections N and O below, upon the earliest of (a) making twelve (12) consecutive months of self-payments, (b) failing to make the full amount of the self-payment on or before the required due date or (c) no longer being an Employee as defined herein.

Upon payment by the Employer for delinquent contributions for work months in which the employee previously made self-payments or reduced his/her dollar bank, the employee shall receive credit to his/her dollar bank in the amount the Employer paid the Fund.

Examples of how this procedure is applied are as follows:

- (i) Employer A fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer A fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer A are sent notification that their Employer will be three (3) months delinquent on July 15. On July 16 the employees are sent notification that their Employer did not make its required Fund contributions and the employees will no longer be receiving credit to maintain eligibility. The employees have until August 10 to either self-pay or use the amounts accumulated in their respective dollar bank. On September 1, Employer A makes full payment to the Fund for the contributions for the work months of April, May, June and July. The employees of Employer A are given credit for the self-payment made on or before August 10 into their dollar banks or if no self-payment was made but their dollar banks were reduced, their dollar banks are reimbursed by the amount contributed to the Fund on each employee's behalf.
- (ii) Employer B fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer B fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer B are sent notification that their Employer will be three (3) months delinquent on July 15. On July 16 the employees are sent notification that their Employer did not make its required contributions and the employees will no longer be receiving credit to maintain eligibility. The employees have until August 10 to either self-pay or use the amounts accumulated in their respective dollar banks. On September 1, Employer B makes a payment to the Fund for the work month of April. Since Employer B did not make full payment for all months delinquent, the employees of Employer B must continue to either make self-payments or deplete their dollar banks or lose eligibility.
- (iii) Employer C fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer C fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer C are sent notification that the Employer will be three (3) months delinquent on July 15. On July 16 the employees are sent notification their Employer did not make its required contributions to the Fund and they will no longer receive credit to maintain eligibility. The employees have until August 10 to either self-pay or use the amounts accumulated in their respective dollar banks. On September 1, Employer C continues to remain delinquent although Employer C is paying one (1) month of full contributions at a time but fails to make full payment to the Fund for all delinquent months. Several employees of Employer C deplete their banked hours and/or fail to make timely self-payments. Those employees lose eligibility and receive COBRA notices in order to maintain health insurance.

- (iv) Employer D fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer D fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer D receive notification that their Employer will be three (3) months delinquent on July 15. Employer D pays the Fund its full contributions for the work month of April prior to July 15. Since the employer is not three (3) months delinquent by July 15, the employees of Employer D do not have to make self-payments or use their respective dollar bank.
  
- (v) Employer E fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer E fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer E are sent notification their Employer will be three (3) months delinquent on July 15. Employer E pays the Fund its contribution for the work month of May (not April) prior to July 15. On July 15, Employer E is delinquent for April and June but not May. Employees of Employer E do not have to self-pay or use their dollar bank. Since Employer E failed to make the payment for the work month of June making Employer E two (2) months delinquent (April and June), the employees of Employer E are sent notification of the delinquency on July 25. The employer pays the Fund full contributions for the work month of July. The employees do not have to use their dollar bank or self-payments (Employer E is only two months delinquent). Employer E fails to pay the Fund contributions for August work month, the employees are sent notification of self-payment by August 25. Employer E fails to make the August work month by September 15. The Employer E employees must self-pay or use their dollar bank by October 10 or Employer E must make full payment for the work months of April, June and August in order for coverage to continue (full payment of one or two months will not be sufficient to prevent Employer E employees from having to use their dollar banks or make self-payments).

### **C. Reinstatement of Eligibility**

If you fail to remain eligible to participate in the Plan pursuant to Article II, Section B, “Continuation of Eligibility,” above, and such failure to remain eligible lasts less than twelve consecutive months, you will again become eligible to participate in the Plan and benefits will be reinstated on the first day of the coverage month following the date on which contributions for:

- (1) one hundred forty-four (144) or more hours during a calendar month; or
  
- (2) two hundred seventy-two (272) or more hours during two (2) *consecutive* calendar months were required to be made, at the rate established by the current collective bargaining agreement, on your behalf by one or more participating Employers. For example, if a contributing Employer is required to pay contributions on your behalf for two hundred seventy-two (272) hours during January and February, you would begin your coverage under the Plan on May 1.

If you fail to remain eligible to participate in the Plan pursuant to Article II, Section B, "Continuation of Eligibility," above, and such failure to remain eligible lasts more than twelve consecutive months, you will again become eligible to participate in the Plan upon the completion of the initial eligibility requirements set forth in Article II, Section A, "Initial Eligibility," above.

In no event may any person become reinstated for eligibility for coverage under the Health Plan if he or she is receiving a pension from either the National Asbestos Workers Pension Fund or the Local #84 Asbestos Workers Pension Fund.

#### **D. Reserve Hours**

Effective for hours worked on or after April 1, 2017, Participants will no longer accumulate Reserve Hours for hours worked. Participants with Reserve Hours balances as of April 1, 2017 will continue to be able to use those Reserve Hours for continued eligibility under the Plan for months after April 2017. However, once those Reserve Hours are exhausted, the Participant will no longer be able to use Reserve Hours for continued eligibility because there will be no more Reserve Hours accumulated on or after April 1, 2017.

Reserve Hours will be used to provide continuous eligibility only, and will not be used to establish or reestablish initial eligibility. The Board of Trustees may, in its sole and absolute discretion, adjust the number of Reserve Hours or eliminate Reserve Hours, and its decision will be final and binding. Reserve Hours are not a vested or an accrued benefit and may be lost under certain conditions determined by the Board of Trustees.

If you retire under the National Asbestos Workers Pension Plan or the Insulators Local 84 Pension Plan, you may use your Reserve Hours to maintain your eligibility under this Plan. Further, if you have insufficient Reserve Hours to satisfy the monthly requirement of one hundred thirty-six (136) hours and fail to maintain your eligibility through timely self-contributions in the invoiced amount, your existing Reserve Hours balance will be forfeited.

#### **E. Termination of Eligibility**

Your eligibility will terminate on the first day of the calendar month following a calendar month in which you have:

- (1) after expending all unused Reserve Hours, fewer than one hundred thirty-six (136) hours, and you fail to make a timely self-contribution payment or make a timely self-contribution payment in less than the invoiced amount; or
- (2) lost Union membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws. As of the date of the loss of union membership and upon notification to the Fund Office, you will not be eligible to make self-contributions and you shall forfeit all unused Reserve Hours.

If you have your eligibility terminated, you may elect to continue your health coverage under the Plan as provided for under Article II, Sections N and O below. In the event an Employer is

delinquent in the payment of its Employer Contributions on your behalf, the Trustees will credit you as though the Employer Contributions were paid by the Employer.

#### **F. Special Enrollment Rights**

If you are declining or declined enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your Dependents' other coverage). However, you must request enrollment within 30 days after you or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage), or within 60 days if an employee's or dependent's coverage is terminated under Medicaid or under a state child health insurance plan (CHIP).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Third Party Administrator at the address listed above.

#### **G. Employment Outside of Jurisdiction**

A participating Employer may continue to contribute on your behalf for work performed outside the territorial jurisdiction of the Fund only if approved by the Board of Trustees.

#### **H. Maintenance of Eligibility**

If you are eligible to participate and are receiving accident and sickness benefits or are receiving benefits under any workers' compensation or occupational disease law, you shall, beginning with:

- (1) the first day of a disability caused by accident; or
- (2) the eighth day of a disability caused by sickness,

receive thirty-five (35) hours of contribution credit for each week you are entitled to or drawing such benefits, up to a maximum total credit of nine hundred ten (910) hours.

#### **I. Military Service**

If you are called to military service with the United States Armed Forces other than for temporary service, you may elect to continue coverage under the Plan for yourself, without any reduction in benefits, for a period not exceeding eighteen (18) months. In the case of temporary service, you will receive thirty-five (35) hours of contribution credit for each week of such service, up to a maximum of one hundred and forty (140) hours.

If you are called to non-temporary military service, you will be provided with the following three (3) options:

- (1) First Option. You may elect not to continue the medical coverage under the Plan for yourself, in which case your eligibility, including your continuation of eligibility [the look-back period], would freeze, and you would resume your eligibility and continuation of eligibility under the Plan when you return from military service. Any accumulated eligibility to your credit on the Plan's records will be maintained and will be made available to you when you return from military service. Upon discharge from military service, and upon written notice given within thirty-one (31) days of the discharge, your "frozen" eligibility will be reinstated effective on the first day of the then current benefit period. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") when you return from military service.
- (2) Second Option. You may elect to continue medical coverage under the Plan for yourself by submitting to the Fund Office monthly premiums for a period not exceeding eighteen (18) months. The monthly premium paid by you will be at the COBRA premium rate. Your continuation of eligibility [the look-back period] would freeze, and you would resume your continuation of eligibility under the Plan when you return from military service. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in USERRA when you return from military service.
- (3) Third Option. You may elect to continue medical coverage under the Plan for yourself for a period not exceeding eighteen (18) months. However, if you have a preexisting medical condition and/or are receiving medical treatment from a medical provider or physician which is not covered under the medical insurance provided by the military armed services, then you may continue your eligibility and continuation of eligibility [the look-back period] until exhausted. After you exhaust your eligibility and continuation of eligibility, then you would submit monthly payments at the COBRA premium rate to the Fund Office for the balance of the eighteen (18) month period. When you return from military service, you would have to satisfy the Plan's initial eligibility provisions to resume coverage under the Plan.

In order for the Plan to properly handle your medical coverage during your period of military service, you must affirmatively elect, in writing, one of these three options. Likewise, when your military service ends, you are required to timely notify the Fund Office of the date you were discharged from military service.

To qualify for the protection given to those in military service under USERRA, your period of military service may not exceed five (5) continuous years, you must not have been discharged from military service under dishonorable or other punitive conditions, and you must report back to work for your Employer in a timely manner and/or contact the Union office to sign up for employment.

**J. Termination of Coverage and Loss of Reserve Hours for Employment with Non-Contributory Employer**

You shall cease to be eligible to be a Participant in this Plan if you are employed by an employer that is not obligated to make contributions to this Plan unless the purpose of such employment is to encourage the employer to become signatory and begin making contributions to this Plan and you enter into a written salting agreement with the Union. Your coverage under this Plan shall terminate on the last day of the calendar month during which such employment occurs. In addition, you shall also lose any accumulated Reserve Hours.

If you are eligible for retiree benefits as described in Article IV below, you shall be exempt from this Section, provided that you are:

- (1) employed by an Employer performing work within the trade jurisdiction as defined in the current Constitution of the International Association of Heat and Frost Insulators and Allied Workers; and
- (2) the Employer is required to make contributions to this Plan on behalf of its bargaining unit employees but not for you.

**K. Eligibility through Reciprocity**

You are eligible to be a Participant in this Plan if you are employed by an Employer who is obligated to make contributions pursuant to a reciprocal agreement with the Insulators Local 84 Health Care Plan. If you have signed an authorization letter with the Insulators Local 84 Health Care Plan, the monies will be transferred as provided under the applicable reciprocal agreement entered into between the participating funds.

Transferred monies will first be allocated to the Health Care Plan in an amount equal to the amount required under the current contribution rate to maintain your Health Care Plan coverage. Any monies in excess of the amount required to maintain your Health Care Plan coverage will be allocated to your Credit Account under the HRA as described below.

**L. Change in Classification or the Amount of Coverage**

The amount of coverage based on your classification is shown in the schedule of benefits. The change will take effect on the day of the change.

**M. When Coverage Ends**

Your coverage will end at midnight on the earliest of:

- (1) the day the Plan ends; or
- (2) the day any self-contribution is due and unpaid; or

- (3) the day before entering military service on active duty (except for temporary active duty of four (4) weeks or less); or
- (4) the day in which you lose your eligibility; or
- (5) the end of the month in which you become employed by an Employer that is not obligated to make contributions to this Fund, as described in Article II, Section J above.

#### **N. Disability Coverage**

If you are found to be totally disabled by the Trustees, then you shall be allowed to make Self-Contributions for the full amount and continue participation in the Plan (the coverage shall remain either single or family, depending on what coverage you have at the time of the disability).

If, in the opinion of the Trustees, you become able to work in the trade as defined by the Constitution of the International Association of Heat and Frost Insulators and Allied Workers, then your disability coverage will terminate at the end of the calendar month in which you are no longer disabled. You would then be eligible to continue as a Participant without requalifying.

Upon the request of the Trustees, you or your Dependent may be required, as a condition to continuing your eligibility under this Plan, to apply for Social Security Benefits, Medicare and Medicaid, or the program then in effect. You or your Dependent may also be required, as a condition to continuing eligibility under this Plan, to sign any authorizations or releases provided by the Trustees, as the Trustees deem necessary, enabling the Trustees to obtain information from you or your Dependent and appropriate government agencies pertaining to your or your Dependent's claim for Social Security Benefits, Medicare and Medicaid benefits.

#### **O. Non-Bargaining Employee Coverage**

Employers are required to contribute on behalf of all nonseasonal, full-time nonbargaining unit employees, defined as officers, owners, partners, shareholders, managers, clerical workers, estimators, supervisors and any other full-time employees (hereinafter collectively referred to as "Nonbargaining Unit Employees"), if they elect such participation in the Plan and enter into a participation agreement with the Trust Fund (subject to the review and approval of, and any other conditions regarding contributions and participation imposed by the Trustees), at the contribution rate determined by the Board of Trustees. Employers that elect to have Nonbargaining Unit Employees participate in the Plan shall be required to contribute at the contribution rate determined by the Board of Trustees to become eligible initially and to remain eligible thereafter. The number of Nonbargaining Unit Employees who become Participants as a result of a participation agreement shall not exceed ten percent (10%) of the total number of Participants.

**P. Summary of Rights and Obligations Regarding Continuation of Group Health Insurance Coverage under Plan through Self-Contribution**

**(1) COBRA Continuation Coverage for Single Employees**

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 and related regulations and amendments (“COBRA”), any member who loses coverage under the Plan by reason of a life event known as a “qualifying event” may elect to continue health coverage under the Plan on a temporary basis from the day the member’s eligibility ends. Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a “Qualified Beneficiary.” A Qualified Beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent Children of employees may be Qualified Beneficiaries. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- (i) Your hours of employment are reduced, or
- (ii) Your employment ends for any reason other than your gross misconduct.

**(2) COBRA Continuation Coverage for Employees Who Have Elected Eligible Dependent Coverage**

A special rule applies if you are an Eligible Dependent of an Employee and you are covered as an Eligible Dependent under the Plan. In such cases, you will become a Qualified Beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your Spouse dies;
- (2) Your Spouse’s hours of employment are reduced;
- (3) Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- (4) Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your Spouse.

Your dependent Children will become Qualified Beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-Employee dies;
- (2) The parent-Employee’s hours of employment are reduced;

- (3) The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The Child stops being eligible for coverage under the Plan as a "Dependent Child."

### **(3) Qualifying Event**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For other qualifying events (divorce or legal separation of the Employee and the Spouse, or a dependent Child's losing eligibility for coverage as a dependent Child), you must notify the Plan Administrator. **The Plan requires you to notify the Plan Administrator within 60 days after the date you lose coverage.** You must send this notice to:

BeneSys, Inc.  
33 Fitch Boulevard  
Austintown, OH 44515  
Phone: (330) 779-8884  
Fax: (330) 270-0912

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees can elect COBRA continuation coverage on behalf of their Spouses, and parents can elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, enrollment of the Employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent Child's losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to thirty-six (36) months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a

covered Employee became entitled to Medicare eight (8) months before the date on which employment terminated, COBRA continuation coverage for his or her Spouse and Children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months (36 minus 8 months) after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of eighteen (18) months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**(4) Disability Extension of 18-Month Period of Continuation Coverage**

If you (or anyone in your family covered under the Plan if he or she is covered as an Eligible Dependent under the Plan) are determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you (and your entire family, if applicable) can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. **You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within sixty (60) days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage.** This notice should be sent to:

BeneSys, Inc.  
33 Fitch Boulevard  
Austintown, OH 44515  
Phone: (330) 779-8884  
Fax: (330) 270-0912

The extended coverage terminates:

- (1) upon your receiving Medicare; or
- (2) thirty (30) days after the month in which the Social Security Administration determines you are no longer disabled.

**(5) Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**

If you (or anyone in your family covered under the Plan if he or she is covered as an Eligible Dependent under the Plan) experience another qualifying event while receiving COBRA continuation coverage, you (or your Spouse and dependent Children in your family, if applicable) can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months.

This extension is also available to a Spouse and/or dependent Children of a former Employee who were covered as Eligible Dependents under the Plan if the former Employee dies, enrolls in

Medicare (Part A, Part B, or both), or gets divorced or legally separated. Similarly, the extension is available to a dependent Child when that Child stops being eligible under the Plan as an Eligible Dependent.

**In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within sixty (60) days after the second qualifying event occurs.** This notice must be sent to:

BeneSys, Inc.  
33 Fitch Boulevard  
Austintown, OH 44515  
Phone: (330) 779-8884  
Fax: (330) 270-0912

**(6) If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact BeneSys, Inc., 33 Fitch Boulevard, Austintown, OH 44515, Phone (330) 779-8884, Fax (330) 270-0912, or you may contact the nearest Regional or District Office of the United States Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**(7) Duty to Keep Plan Administrator Informed of Address Changes**

In order to protect your rights (and your family's rights, if applicable), you should keep the Plan Administrator informed of any changes in your address (and the addresses of family members, if applicable). You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**(8) Payment for COBRA Coverage**

Any member (or other individual) who has the right to COBRA coverage ("Qualified Beneficiary") must complete the application and make the first payment within the time limits as set forth herein. The Plan is not required to segregate any dental, vision and other miscellaneous benefits provided by the Plan from the COBRA benefit package. The Plan will offer the same COBRA benefit package to a Qualified Beneficiary as the COBRA benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event, including dental, vision care, or any other health care benefits that were part of the Qualified Beneficiary's benefit package on the day before the qualifying event. In addition, if the Plan permits members to elect among different benefit packages, then after the qualifying event the Plan does not have to provide the Qualified Beneficiary with an election among the different benefit packages and will offer only the same benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event.

The Qualified Beneficiary has sixty (60) days from the date he or she loses regular coverage to elect COBRA continuation coverage. COBRA continuation coverage will be made available for the entire sixty (60) day election period if the Qualified Beneficiary elects COBRA continuation

coverage prior to the end of the election period. A Qualified Beneficiary may reject or waive COBRA continuation coverage but then revoke the waiver at any point during the sixty (60) day period and elect COBRA continuation coverage; however, if this occurs, the COBRA continuation coverage will not apply retroactively to the beginning of the sixty (60) day election period but applies only back to the date on which the rejection or waiver was revoked and COBRA continuation coverage was elected. The Qualified Beneficiary is not covered during the election period prior to his or her election, but will have retroactive coverage if COBRA continuation coverage is timely elected and timely paid.

The Fund Office will inform the Qualified Beneficiary of the monthly premium to be paid. The Qualified Beneficiary has forty-five (45) days from the date he or she elects COBRA continuation coverage to make the first payment. After the first payment, the Qualified Beneficiary is allowed thirty (30) days to make each payment after the date it is due. For subsequent months, the Fund Office will bill the Qualified Beneficiary on the fifteenth (15<sup>th</sup>) day of the month preceding the month in which the Qualified Beneficiary receives coverage. The Qualified Beneficiary is not covered during the forty-five (45) day grace period permitted for payment of the first COBRA premium or during the thirty (30) day grace period permitted for payment of the monthly COBRA premium prior to his or her timely payment of the COBRA premium, but will have retroactive coverage if the COBRA premium is timely paid.

The cost of COBRA continuation coverage will not exceed 102% of the premium applicable to active employees. However, a Qualified Beneficiary who has been determined disabled as defined by the Social Security Administration and requests coverage for an additional eleven (11) months for a total of twenty-nine (29) months of continuation coverage may be required to pay a premium which is one hundred fifty percent (150%) of the amount of the regular COBRA premium for all months of coverage after the first eighteen (18) months. In addition, the cost of COBRA continuation coverage may be increased at any time when the Plan is charging less than the allowable COBRA premium (i.e., less than the 102% or the 150%) or in a situation where a Qualified Beneficiary is permitted by the Plan's rules and procedures to change to a more expensive form of coverage under the Plan.

#### **(9) Cancellation of COBRA Coverage**

Coverage ends immediately for any member who:

- (1) Fails to make a premium payment on time. After the first payment, the person is allowed thirty (30) days to make each payment after the date it is due. If it is not post-marked on or before the end of the 30-day period, COBRA coverage will be canceled as of the due date; or
- (2) First becomes enrolled in either Part A or Part B of Medicare after the date of the qualifying event; or
- (3) First becomes covered under another group health care plan after the date of the qualifying event, except that if the Member has a pre-existing condition that is not

covered under the new employer's plan, then the Member may continue COBRA coverage under this Plan for the remainder of the continuation coverage period; or

- (4) COBRA coverage will also be canceled as of the date the Plan terminates and no longer provides group health coverage; or
- (5) COBRA coverage will also be canceled on the date on which the COBRA continuation coverage period applicable to the Qualified Beneficiary expires.

### **III. DEPENDENTS' ELIGIBILITY**

#### **A. Eligible Dependents**

The Plan provides coverage for Eligible Dependents. An Eligible Dependent shall be considered eligible for coverage on the date the Employee becomes eligible for benefits, subject to all limitations and requirements of the Health Plan, and according to the following:

- (1) Newborn Children of an Eligible Employee will be covered from the moment of birth, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the Child is properly enrolled as an Eligible Dependent of the Eligible Employee within thirty (30) days of the Child's date of birth. If not, the Eligible Dependent will be covered from the date of enrollment.
- (2) A Spouse will be considered an Eligible Dependent from the date of marriage, provided the Spouse is properly enrolled as an Eligible Dependent of the Eligible Employee within thirty (30) days of marriage. If not, the Eligible Dependent will be covered from the date of enrollment.
- (3) If an Eligible Dependent is acquired, other than at the time of birth, due to a court order, decree or marriage, that Eligible Dependent will be considered an Eligible Dependent from the date of such court order, decree or marriage, if this new Eligible Dependent is properly enrolled as an Eligible Dependent of the Eligible Employee within thirty (30) days of the court order, decree or marriage. If not, the Eligible Dependent will be covered from the date of enrollment.
- (4) Adopted Children of an Eligible Employee will be eligible for coverage as of the date of legal custody, or as of the date of actual adoption, whichever occurs first. Coverage under the Health Plan for the Child shall be the same coverage which is available to all other Eligible Dependent Children under the Plan.

An adopted Child of an Eligible Employee who is otherwise eligible for coverage under this Health Plan shall remain eligible even though such individual is eligible for coverage under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Medicaid"). The Health Plan will make payment of all benefits under the Health Plan for an adopted Child covered by

Medicaid coverage in accordance with the assignment of rights requirements of that adopted Child's Medicaid coverage. Coverage provided by the Health Plan shall be considered primary coverage and shall pay services before Medicaid.

If the Participant's coverage is canceled, Dependent coverage is also canceled, except as provided by COBRA. In addition, an Eligible Dependent loses regular coverage as of the date:

- (1) family coverage is canceled for the class of Employees to which the Participant belongs; or
- (2) the individual ceases to meet the Health Plan's requirements to qualify as an Eligible Dependent.

The Trustees have the sole discretion to determine:

- (1) if your Spouse or your Child qualifies as an Eligible Dependent, and
- (2) the definition of an "Eligible Dependent," where there is a possible ambiguity.

The determination of the Trustees shall be final, binding and conclusive.

#### **B. Dependents Not Eligible**

The following are not Eligible Dependents:

- (1) your spouse from whom you are divorced or legally separated, effective on the date of the decree of legal separation, divorce or dissolution; or
- (2) an individual eligible for coverage under the Plan as an Employee or member; or
- (3) a Child who has obtained the Limiting Age. The Limiting Age is the Child's 26<sup>th</sup> birthday.

#### **C. Mentally or Physically Disabled Child**

The coverage for a physically handicapped or intellectually disabled Child of yours who attains the Limiting Age while insured under the Plan may be continued if the Child or Children are:

- (1) unmarried; and
- (2) chiefly dependent on you for support; and
- (3) unable to support themselves.

The coverage will continue only if the Board of Trustees receives proof of the Child's disability from a physician who medically certifies that the child has a physical handicap or mental disability:

- (1) no later than thirty-one (31) days after the Child attains the Limiting Age; and
- (2) thereafter the Board of Trustees may require additional proof, but not more often than once every two years.

Determination of whether such unmarried Child over the Limiting Age qualifies as an Eligible Dependent pursuant to this Section will be made by the Trustees in their sole discretion and the Trustees determination shall be final, binding and conclusive.

**D. When Dependent's Coverage Begins**

- (1) A Dependent's coverage will begin the later of:
  - (i) the day you are insured; or
  - (ii) the day you first acquire an Eligible Dependent.
- (2) Once you have an Eligible Dependent insured, any newly acquired Eligible Dependent will be insured upon your notification to the Third Party Administrator.

**E. When Dependent's Coverage Ends**

A Dependent's coverage will end at midnight on the *earliest* of:

- (1) the last day of the month in which your Dependent is no longer eligible under the Plan, if loss of eligibility is due to reasons other than divorce or marriage; or
- (2) the last day of the month in which your Dependent is no longer eligible under the Plan, if loss of eligibility is due to divorce or marriage; or
- (3) the day any self-pay premium/contribution is due and unpaid; or
- (4) the day the Plan terminates; or
- (5) the day before a Dependent enters military service on active duty (except for temporary active duty of four weeks or less); or
- (6) the day your eligibility terminates.

## **F. Surviving Spouse's Continuing Coverage**

If you die, then coverage for your surviving Spouse who qualifies as an Eligible Dependent will continue until your eligibility is exhausted. Coverage of your surviving Spouse will terminate if your surviving Spouse remarries or fails to make the required payment to continue coverage. The premium for surviving spouse coverage is subject to change by the Board of Trustees and may be obtained by contacting the Third Party Administrator.

Your surviving spouse may also elect to continue coverage for your dependent Children who qualify as Eligible Dependents.

An insured Spouse and/or insured dependent Child may also elect to continue health insurance when eligibility ends in accordance with the provisions of COBRA, as described above. In the event that more than one continuation provisions apply, the periods of continued coverage will run concurrently.

## **IV. RETIREE PROGRAM ELIGIBILITY FOR RETIRED EMPLOYEES**

The Trustees reserve the right to change or eliminate the Retiree Programs, including, but not limited to, the benefits available, at their sole discretion, at any time and for any reason. Participants and retired Employees do not have any vested rights in the Retiree Programs.

### **A. Eligibility Requirements for Retired Employees**

A retired Employee who was a Participant in the Plan may become eligible for retiree benefits only if he/she meets all of the following requirements:

- (1) On the date you retire you are a member in good standing of Local 84.
- (2) You are retired from active employment as evidenced by the receipt of benefits under the National Asbestos Workers Pension Plan or the Insulators Local 84 Pension Plan.
- (3) You were eligible for active Employee coverage under the Plan on the date you retired.

If you qualify under the above rules, you may elect to continue coverage under this Plan as a retired member by using your Reserve Hours to satisfy the monthly requirement of one hundred thirty-six (136) hours. Thereafter, you may continue coverage by paying the current self-pay rate established by the Board of Trustees. Your Reserve Hours will be exhausted prior to any self-payment. You must make self-payments in accordance with the requirements of the Fund Office as determined by the Board of Trustees. Your self-payments must be received by the Fund Office no later than the 10<sup>th</sup> day of each month.

The amount of the required monthly self-payment for participation in the Retiree Program shall be determined by the Board of Trustees and is subject to change. You may obtain the current monthly self-payment amount from the Third Party Administrator.

Both the extent of coverage and the amounts of self-payment are subject to revision by the Trustees in accordance with any applicable results.

If you qualify under these rules of eligibility to participate in the Retiree Program, then you must elect coverage within the first sixty (60) days after the last month in which you were covered for benefits under the Plan and make the required self-payments in accordance with the requirements of the Fund Office as set by the Board of Trustees. If you do not elect coverage within the sixty (60) day period or make the required self-payments timely to the Fund Office, you will not be eligible for coverage at any time in the future, and you will be notified that you may continue coverage at your own expense as provided for under COBRA, as described above.

### **B. Limits on Retiree Actively Working at the Trade**

It is a condition to coverage under this Plan that the Eligible Retiree shall not engage in or perform employment in the trade jurisdiction, as defined in the current Constitution of the International Association of Heat and Frost Insulators and Allied Workers, for remuneration or profit, except that an Eligible Retiree may work:

- (1) as an instructor in a recognized apprenticeship program of the International Association of Insulators and Allied Workers; or
- (2) as an Employee for an Employer contributing to the Plan if such employment does not exceed a total of eight hundred (800) hours worked in a calendar year.

Your coverage will terminate on the first day of the month following the month in which you either:

- (1) obtain employment, without following all of Local 84's procedures, in which you use the knowledge, skill, or experience gained as an Insulator Worker; or
- (2) obtain employment with an Employer contributing to the Plan and work in excess of eight hundred (800) hours in a calendar year. The Board of Trustees shall determine if an Eligible Retiree is engaging in or performing disqualifying employment.

### **C. Change of Eligibility Rules and Schedule of Benefits**

The Trustees have granted retiree benefits as a privilege, not a right. No person has any vested right in any retiree benefits. The Trustees, in their sole discretion, are empowered to change or amend the foregoing rules of eligibility or the Schedule of Benefits at any time. Further, the Trustees may expand, reduce, or cancel the Retiree Program, change the cost of contributions, and otherwise exercise their prudent discretion at any time without legal right or recourse by a retiree or any other person.

#### **D. Medicare Supplement and Medicare Drug Coverage for Medicare-Eligible Retirees**

If you are eligible for coverage under Medicare, your Medicare Supplement Plan and your prescription drug benefit will be provided through a fully insured Plan entered into by the Board of Trustees for Medicare-Eligible Retirees. Your coverage will be based on the terms of those plans. The Plans will be administered through an independent Medicare Management Company called Labor First, LLC. For information related to coverage under the Medicare supplement and prescription drug plans, contact Labor First at (330) 299-4155 (TTY 711) or Toll Free at (855) 531-8840.

#### **E. Incorporation of Other Plan Documents**

All basic plan documents and all definitions, terms, conditions and provisions therein are adopted and made a part of this Plan. Any questions, interpretations and disputes concerning eligibility for and amount of benefits shall be resolved by the Trustees in their sole discretion and shall be final, binding and conclusive.

#### **F. Termination of Benefits**

Benefits under the Retiree Program shall terminate for you when you indicate an intention to no longer participate in the Plan or you fail to make the required payments as provided in Section C above.

If you return to employment covered by this Plan and work for more than eight hundred (800) hours in a calendar year, your coverage as a Retiree will terminate at the earlier of either (1) the first of the month following the date on which your total hours worked in a calendar year for an Employer contributing to the Plan exceeds eight hundred (800) hours; or (2) immediately once you become employed in the insulation industry within the geographical jurisdiction of the International Association of Heat and Frost Insulators and Allied Workers by a non-participating employer, unless such work is pursuant to a written agreement between Local 84 and yourself. If you gain eligibility as an active eligible Employee, you will receive benefits as an active eligible Employee and no longer be required to make payments for Retiree benefits.

When you stop working in employment covered by this Plan, you will continue your eligibility as an active eligible Employee until your eligibility terminates, at which time no self-payments may be made to continue active eligibility. At that time, you may reinstate your coverage as a Retiree if you meet the requirements of Article IV, Section A. (Please note: the five year requirement includes time before and after your initial retirement.) You may become eligible for Retiree coverage only twice. If your coverage is terminated a second time, you are **not** eligible for any successive coverage.

#### **G. Retired Employee's Surviving Spouse's Continuation**

If you die while receiving benefits under the Retiree Program, then coverage for your surviving Spouse who qualifies as an Eligible Dependent will continue until your eligibility is exhausted.

Afterwards, your surviving spouse may elect to continue coverage, provided (1) he or she has been married to you for at least one (1) year immediately prior to your death, (2) there is no other group health benefits coverage on the surviving Spouse [exclusive of Medicare], and (3) the surviving Spouse makes the required payment to continue coverage as determined by the Trustees. Coverage of your surviving Spouse will terminate if the surviving Spouse remarries or fails to make the required payment to continue coverage.

Your surviving Spouse may also elect to continue coverage for your dependent Children who qualify as Dependents. If your Dependents are not your natural born Children but became your Dependents as a result of marriage less than one (1) year prior to your death, their benefits will terminate upon your death. Continuing coverage for your Dependents is available only if your surviving Spouse elects continuing coverage for himself or herself. If your surviving spouse does not elect continuing coverage for himself or herself, your Dependents may not independently elect continuing coverage for themselves. If your surviving Spouse elects continuing coverage for himself or herself and also for your Dependents, their continuing coverage will end upon your surviving Spouse’s death.

An insured Spouse and/or insured dependent Child may also elect to continue health insurance when eligibility ends in accordance with the provisions of COBRA, as described above. In the event that more than one continuation provisions applies, the periods of continued coverage will run concurrently.

**V. SCHEDULE OF BENEFITS**

**A. Eligible Active Employees, Dependents, and Pre-Medicare Retirees**

The following chart summarizes medical and other benefits that are available to active Employees, their Eligible Dependents, if any, and Pre-Medicare Retirees:

**COMPREHENSIVE MEDICAL BENEFITS**  
**ELIGIBLE ACTIVE EMPLOYEES, DEPENDENTS, AND PRE-MEDICARE**  
**RETIREES**

<b>BENEFIT PERIOD AND DEPENDENT AGE LIMIT</b>	
Benefit Period	June 1 <sup>st</sup> to May 31st
Dependent Age Limit	The end of the month of the 26 <sup>th</sup> birthday

<b>PPO NETWORK COMPREHENSIVE MAJOR MEDICAL BENEFIT</b>	
PPO Network Provider Deductible per Benefit Period	
If you have single coverage:	\$1,500
If you have family coverage:	\$3,000
Non-PPO Network Provider Deductible per Benefit Period	
If you have single coverage:	\$3,000
If you have family coverage:	\$6,000

PPO Network Provider Coinsurance Limit per Benefit Period	
If you have single coverage:	\$4,150
If you have family coverage:	\$8,300
Non-PPO Network Provider Coinsurance Limit per Benefit Period	
If you have single coverage:	Unlimited
If you have family coverage:	Unlimited
PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	\$5,650
If you have family coverage:	\$11,300
Non-PPO Network Provider Out-of-Pocket Maximum per Benefit Period (Includes Deductibles, Copayments, and Coinsurance)	
If you have single coverage:	Unlimited
If you have family coverage:	Unlimited
Deductible and Out-of-Pocket Maximum Processing (1)	Embedded

**After the applicable Out-of-Pocket Maximum shown above has been met, you are no longer responsible for paying any further Copayments, Deductibles or Coinsurance for Covered Charges Incurred during the balance of the Benefit Period. If the out-of-Pocket Maximum is Unlimited, you continue to be responsible for paying the amounts shown above.**

**Any Excess Charges you pay for claims will not accumulate toward any applicable Coinsurance Limit or toward the Out-of-Pocket Maximum.**

Deductible accumulations are separate.

Any amounts applied to your PPO Network Coinsurance Limit will also be applied to your Non-PPO Network Coinsurance Limit. Any amounts applied to your Non-PPO Network Coinsurance Limit will also be applied to your PPO Network Coinsurance Limit.

To receive maximum benefits, you must use PPO Network Providers.

**Remember, in an emergency, always go to the nearest appropriate medical facility; your benefits will not be reduced if you go to a Non-PPO Network Hospital in an emergency.**

<b>BENEFIT MAXIMUMS FOR COVERED PERSONS</b>	
(per Benefit Period unless otherwise shown)	
Outpatient Professional Occupational and Physical Therapy Services and Chiropractic/Spinal Manipulation Visits	20 visits (combined), then subject to medical review
Routine Chest X-ray, Complete Blood Count (CBC), Electrocardiogram (EKG), Comprehensive Metabolic Panel and Urinalysis (UA)	One Each

Routine Mammogram Services	One mammogram; mammograms are limited to 130% of the Medicare reimbursement amount applies only to Covered Services received in the State of Ohio, as mandated by the State of Ohio
Routine Pap Tests and Associated Examinations	One test One examination
Routine Physical Examinations (age 21 and over)	Males – One examination Females – Two examinations
Sleep Study	One study

<b>COINSURANCE</b>		
<b>TYPE OF SERVICE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
	The portion of Institutional and Professional Charges you pay for Covered Services received from a PPO provider, based on the allowed amount	The portion of Institutional and Professional Charges you pay for Covered Services received from a non-PPO provider, based on the allowed amount or Non-Contracting Amount (2)
<b>IF A DEDUCTIBLE APPLIES, ALL COVERED SERVICES ARE SUBJECT TO THE DEDUCTIBLE, UNLESS “NOT SUBJECT TO THE DEDUCTIBLE” IS SPECIFICALLY STATED.</b>		
<b>EMERGENCY ROOM SERVICES</b>		
The Institutional charge for use of the Emergency Room for an Emergency Medical Condition	20%	
All other related Institutional charges and Emergency Room Physician’s chares for an Emergency Medical Condition	20%	
The Institutional charge for use of the Emergency Room in a <b>non-emergency</b>	20%	40%
Emergency Room Physician’s Charges in <b>non-emergency</b>	20%	40%
<b>INPATIENT SERVICES</b>		
Maternity	20%	40%
Physical Medicine and Rehabilitation	20%	40%
Semi-Private Room and Board	20%	40%
Skilled Nursing Facility	20%	40%
<b>MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES</b>		
Mental Health Care, Drug Abuse and Alcoholism Services	Any applicable Deductible, Out-of-Pocket Maximum or Copayment corresponds to the type of service received and is payable on the same basis as any other illness (e.g., emergency room visits for a Mental Illness will be paid according to the Emergency Services section above).	

<b>OUTPATIENT REHABILITATIVE SERVICES</b>		
Cardiac Rehabilitation Services	20%	40%
Chiropractic Services	20%	40%
Occupational and Physical Therapy Services	20%	40%
Respiratory/Pulmonary Therapy Services	20%	40%
Speech Therapy Services	20%	40%
<b>PHYSICIAN/OFFICE SERVICES (includes Mental Health and Substance Abuse Disorders)</b>		
Immunizations	20%	40%
Medically Necessary Office Visits	20%	40%
Urgent Care Office Visits	20%	40%
<b>ROUTINE, PREVENTIVE AND WELLNESS SERVICES</b>		
Preventive Services in accordance with state and federal law (3) (Please refer to the “Routine, Preventive and Wellness Services” benefit in this SPD for more information.)	0%, not subject to the Deductible	
Routine Colonoscopy (Ages 50 and over) and Sigmoidoscopy (Ages 40-75) (4)	0%, not subject to the Deductible	Not Covered
Routine Mammograms	0% not subject to the Deductible	Not Covered
Routine Pap Tests and Associated Examinations	0%, not subject to the Deductible	
Routine Physical Examinations (Age 21 and over)	0%, not subject to the Deductible	
Routine Testing Services: <ul style="list-style-type: none"> <li>• Bone Density (Ages 50 and over)</li> <li>• Chest X-ray</li> <li>• Complete Blood Count (CBC)</li> <li>• Comprehensive Metabolic Panel</li> <li>• Electrocardiogram (EKG)</li> <li>• Urinalysis (UA)</li> </ul>	0%, not subject to the Deductible	
Well Child Care Services (Under age 21)	0%, not subject to the Deductible	
<b>SURGICAL SERVICES</b>		
Inpatient Surgery	20%	40%
Medically Necessary Colonoscopy	20%	Not Covered
Medically Necessary Endoscopic Procedures (i.e. Sigmoidoscopy, Anoscopy, Proctosigmoidoscopy)	20%	40%
Outpatient Surgery	20%	40%
<b>OTHER SERVICES</b>		
Ambulance Services	20%	
All Other Covered Services	20%	40%

1. “Embedded processing” – A family plan with two kinds of deductibles and Out-of-Pocket Maximums: one for an individual family member and one for the whole family. With family coverage, each Covered Person’s Out-of-Pocket Maximum will not exceed the Out-of-Pocket Maximum for single coverage shown on the Schedule of Benefits.
2. The Coinsurance percentage will be the same for Non-Contracting Provider’s as Non-PPO Network Providers but you may still be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.
3. Preventive services include evidence-based services that have a rating of “A” or “B” in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care act.
4. If a diagnosis of a medical Condition is made during a colonoscopy screening (e.g., removal of a polyp for a person over age 75), the procedure is not considered routine and may be considered a diagnostic procedure under Surgical Services.

**Prescription Benefits  
Eligible Active Employees, Dependents, and Retirees**

Prescription drug benefits under the Plan are administered by a Third-Party Pharmacy Benefit Manager. Your prescription drug benefits are more fully described in the prescription drug benefit booklet prepared by the Pharmacy Benefit Manager. The following is a summary of the major limitations on your prescription drug benefits. For complete information, you should refer to the booklet prepared by the Pharmacy Benefit Manager.

<b>Prescription Benefits</b>		
<b>Maximum Prescription Benefit per Plan Year</b>	None	
<b>Out-of-Pocket Maximum for Prescription Essential Health Benefits (single coverage)</b>	\$1,500.00	
<b>Out-of-Pocket Maximum for Prescription Essential Health Benefits (family coverage)</b>	\$3,000.00	
<b>Retail Prescription, up to 30-day supply; limited to 3 fills</b> (Aspirin and other over the counter drugs are covered without copays only when prescribed by a Provider as preventative care.)	Generic Prescription Drug	Approved cost of prescription less \$15 co-pay
	Formulary Brand Name Prescription Drug	Approved Cost of prescription less \$40 co-pay
	Non-Formulary Brand Name Prescription Drug	Approved Cost of prescription less \$65 co-pay

<b>Mail Order Prescription; up to 90-day supply; limited to 3 refills; required for maintenance medication</b>	Generic Prescription Drug	Approved cost of prescription less \$38 co-pay
	Formulary Brand Name Prescription Drug	Approved cost of prescription less \$100 co-pay
	Non-Formulary Brand Name Prescription Drug	Approved cost of prescription less \$163 co-pay

Exclusions include vitamins, Rogaine, Viagra, fertility drugs, erectile dysfunction drugs, smoking cessation drugs, PCSK9 Inhibitors, and non-specialty injectable drugs. **For “Specialty Drugs,” the co-pay in all cases is 25% of the approved cost of the prescription. Specialty Drugs** are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of a patient's drug therapy. For Specialty Drugs, Participants must first try the formulary drugs on the preferred product list prior to trying a non-preferred brand unless overridden by the treating physician by a separate letter establishing that the non-preferred brand is medically necessary. All compound drugs must be obtained through Orchard Compounding, a Division of Orchard Pharmaceutical Services.

A “dispense as written” penalty (DAW penalty) applies to the use of brand name drugs when a generic version is available. Under the DAW penalty, if a Participant chooses a brand name drug when a generic version is available, the Participant is responsible to pay both the applicable co-pay as well as the cost difference between the brand name drug and the generic drug. The only exception to application of a DAW penalty is if the Participant obtains from their physician a letter of medical necessity establishing that there is a medical need to use the brand name drug instead of a generic drug.

For specialty drugs, Participants must first try the formulary drugs on the preferred product list prior to trying a non-preferred brand unless overridden by the treating physician by a separate letter establishing that the non-preferred brand is medically necessary. For a list of preferred drugs, please contact the Third Party Administrator at the address on the front of the SPD.

### **Death Benefits**

Death Benefit – Active Employees	\$10,000
Death Benefit – Retirees	\$2,000

### **B. Use of Preferred Provider Organization**

The Plan has contracted with a Preferred Provider Organization (hereinafter “PPO”), to provide a network of physicians, hospitals, and other medical service providers. The PPO will provide services to eligible Participants at a reduced fee structure. Participation in the PPO helps to reduce the Plan’s costs and permits you to maximize your benefits.

When you receive health care services from a provider that is not a PPO network provider, your benefits will be reduced. Please see the Schedule of Benefits above for an itemization of benefits for in-network and out-of-network providers.

Use of an in-network provider is necessary for active Eligible Employees, retired Employees who are **not** on Medicare, Surviving Spouses not on Medicare, and Eligible Dependents.

**NOTE:** In an emergency, always go to the nearest appropriate medical facility; your benefits will not be reduced if you go to a Non-PPO Network Hospital in an emergency.

To obtain a directory of in-network providers, contact the Fund Office.

### **C. Weekly Accident and Sickness Benefits**

#### **1. Benefits Available**

The Weekly Sickness and Accident Benefit is available to you if you have met the Plan's eligibility requirements, are an active Participant, and have become Totally Disabled due to a Non-Occupational injury or illness that prevents you from working at your occupation. Weekly Sickness and Accident Benefits are not available to Retirees or your Dependents.

The Weekly Sickness and Accident Benefit is \$300 per week through the twenty-sixth (26<sup>th</sup>) week of disability. Weekly benefits begin on the *earliest* of:

- (i) the first day of a disability caused by accident;
- (ii) the first day of hospitalization;
- (iii) the first day of a surgical procedure performed in an outpatient facility; or
- (iv) the eighth day of a disability caused by other sickness.

For purposes of maintaining your coverage under the Plan during your period of disability, you will be credited with thirty-five (35) hours for each week that the Trustees determine you are Totally Disabled. Your coverage will continue for a maximum of twenty-six (26) weeks during any twelve (12) consecutive month period or for any single disability. This maximum coverage period of twenty-six (26) weeks during a twelve (12) consecutive month period applies even if you have more than one period of disability during a consecutive twelve (12) month period.

**EXAMPLE:** In February you are involved in an accident which results in a continuous period of disability for twenty-four (24) weeks. You receive twenty-four (24) weeks of Weekly Sickness and Accident Benefits. In September you are afflicted with pneumonia, which results in a continuous period of disability for six (6) weeks. You will be eligible for Weekly Sickness and Accident Benefits for only two (2) out of the six (6) weeks because the maximum amount of Weekly Sickness and Accident Benefits payable during any twelve (12) consecutive month period is twenty-six (26) weeks.

Successive periods of disability separated by less than two (2) weeks of continuous employment will be considered one (1) period unless the two disabilities arise from different causes. If the disabilities

arise from different causes, you will be eligible for a new period of disability benefits if you have worked at least one full working day before the second period of disability begins.

**NOTE: The maximum benefit available for any one disability is twenty-six (26) weeks.**

## **2. Limitations**

Determination of whether Sicknesses or Accidents are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

No Weekly Sickness and Accident Benefits will be paid for, or on account of, any period of disability:

- (i) for which you are not under the regular care of a doctor; or
- (ii) for which you have or had a right to payment under any workers' compensation law, occupational disease law or similar law; or
- (iii) which is due to occupational disease or workplace injury; or
- (iv) for which you have or had a right to payment under the temporary disability benefit laws of any state or unemployment; or
- (v) if you are working in any capacity.

**NOTE: Weekly Sickness and Accident Benefits are available for a Non-Occupational disability only.**

## **3. Submission of Claims**

To obtain Weekly Sickness and Accident Benefits, you must provide written notice to the Third Party Administrator within:

- (i) Twenty (20) days after the Accident causing your Total Disability occurs,
- (ii) Twenty (20) days after the first day of hospitalization causing disability,
- (iii) Twenty (20) days after a surgical procedure performed in an outpatient facility causing disability,
- (iv) Within (28) days after the first day of a disability caused by other sickness.
- (v) If written notice cannot be given within that time, it must be given as soon as reasonably possible. The written notice must contain enough information to identify who is making the claim.

When the Third Party Administrator receives written notice of a claim, the Third Party Administrator will send you an approved claim form. You must complete and submit the approved claim form, completed and signed by your Physician stating the nature of the disability, length of disability and date you can return to work. It must also be signed by your Physician.

#### **4. When Benefits End**

Weekly Sickness and Accident Benefits will cease on the earliest of:

- (i) the date you are no longer Totally Disabled; or
- (ii) the end of the maximum benefit period (26 weeks during any 12 month period); or
- (iii) your date of death.

#### **D. Death Benefits**

When a Participant dies, the Plan will pay a death benefit to the Participant's designated beneficiary listed on the appropriate form that is on file at the time of death in a lump sum in the amount set forth in the Schedule of Benefits. If the beneficiary is a minor at the time benefits become payable, the benefits may be paid to the Child's parent or legal guardian as custodian of the minor pursuant to the Ohio Transfers to Minors Act (R.C. Chapter 5814). The death benefit for active Employees is different from the death benefit for Retirees. If the Participant fails to designate a beneficiary on an appropriate form that is on file at the time of the Participant's death or if his or her designated beneficiary is no longer living upon the Participant's death, the death benefit will be paid to the person (or in equal shares to the persons) in the first of the following classes of successive preference beneficiaries then surviving: the Participant's (1) spouse, (2) lineal descendants, (3) parents, (4) siblings, and (5) the Participant's estate, in care of its executor or administrator. A Participant may designate a new beneficiary at any time by filing a written beneficiary change form with the Fund Office. Any change of beneficiary form will *not* be effective until the form is received by the Plan. To be effective, the form must be received prior to the Participant's death.

#### **E. Prescription Benefits**

##### **1. Formulary**

Your prescription drug benefit features a formulary drug list. A formulary is a list of preferred medications organized into groups or "Tiers".

- Tier 1 drugs are generic drugs and are the first choice whenever possible.
- Tier 2 drugs are a set of preferred brand-name drugs.
- Tier 3 drugs are non-preferred brand-name drugs.

Brand name drugs which have a generic available are placed on the non-preferred brand-name Tier 3. For a full formulary listing, please contact the Plan Administrator.

## **2. New-to-Market Medications**

Any medication approved to enter the market will not be covered on your prescription benefit until a clinical review and tier placement decision has been made by the Pharmacy Benefit Manager. This restriction does not apply to new dosage forms/strength changes in existing medications. The Pharmacy Benefit Manager will review safety, efficacy and cost information in order to determine if a new-to-market drug is covered. Each new drug will be reviewed on a quarterly basis.

## **3. Non-Covered Brand Medications**

Coverage for prescriptions to treat the conditions listed below is limited to the most clinically and economically valuable brand drugs as determined by the Pharmacy Benefit Manager:

- Acne
- Androgen
- Diabetes/Glucose Testing Supplies
- Insulin
- Injectable Anti-Diabetic
- Over Active Bladder

Drugs in these categories with equal or lessor clinical benefit and significantly higher cost will be excluded from your prescription drug benefit. For a current list of excluded drugs, please contact your Fund Office.

If the medication selected by your physician is not covered, you should work with your physician to determine if a preferred alternative is an appropriate option for you. If you require the use of a non-covered brand medication, you will need to follow the appeal process to gain approval for this medication.

## **4. Prior Authorization**

Certain medications require prior authorization from the Pharmacy Benefit Manager prior to being covered. A prior authorization requires documentation of medical necessity from your prescribing physician. For a list of medications requiring preauthorization, please contact your Fund Office.

## **5. Step Therapy**

A step therapy program is designed specifically for patients with certain conditions that require taking medications regularly. Step therapy requires beginning medication therapy for a medical condition with the most cost-effective medication and progressing to other costlier alternatives only if the initial medication fails to provide an adequate therapeutic benefit.

In step therapy, medications are grouped into categories, either as (1) Step 1, First Line medications, or (2) Step 2, Second Line medications. You will be required to first try Step1 First Line medications before approval of a more costly and complex Step 2 Second Line medications.

Step therapy programs are currently in place for the treatment of the following conditions: ADD/ADHD, Asthma, Diabetes, Inflammatory Bowel Disease, Opioid Abuse, Stimulants, Multiple Sclerosis, Rheumatoid Arthritis, Growth Hormone, Angiotensin Receptor Blockers, and Antidepressants.

If you are in need of a Step 2 medication, you can either (1) have your prescription write you a prescription for a first line medication or (2) have your physician submit a letter of medical necessity in order to receive the Step 2 medication stating that it is medically necessary for you to be on the exact dosage and quantity. Letters of medical necessity must be submitted annually to the Pharmacy Benefit Manager.

#### **6. Compound Medications Maximum**

Compound medications are medications that result when a licensed pharmacist combines, mixes, or alters ingredients of a drug in response to a prescription to create a medication tailored to the medical needs of an individual patient. Compound medications that cost the Plan \$200.00 or more, per claim, require a letter of medical necessity before being covered. Your physician will need to submit a letter of medical necessity request for your prescription stating that it is medically necessary for you to be on the exact medication, dosage and quantity. The letter of medical necessity is required at least once annually.

#### **7. Out-of-Pocket Maximum**

The prescription plan has a separate out-of-pocket maximum from your comprehensive medical benefit. An out-of-pocket maximum is “the most you must pay during a policy period before your plan will start to pay 100% for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost sharing or spending for non-essential health benefits. The out-of-pocket maximum is listed in the Prescription Benefits table under the Schedule of Benefits section of the SPD.

#### **8. Lifestyle Medication Benefit**

For drugs that are excluded from coverage, including cosmetic drugs, impotency drugs, nutrients and dietary supplements, and weight loss drugs, participants in the Plan are still entitled to receive discounts on such medications at participating pharmacies, but will be responsible to pay one hundred percent (100%) member co-pay of the discounted amount.

#### **F. Exclusions from Medical Coverage**

The Plan provides coverage for most health care expenses you can expect to incur. You should be aware, however, that the Plan does not cover any of the expenses, disabilities, or types of care listed below:

- (1) Work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
- (2) Eye glasses, contact lenses or examinations for prescribing or fitting them, except as described in the section entitled "Prosthetic Appliances" under the "Medical Supplies and Durable Medical Equipment" benefit.
- (3) All services related to hearing loss including hearing aids or examinations for prescribing or fitting them, except as specified (other than newborn screening for hearing loss, as required by PPACA).
- (4) Conditions that occur as a result of any act of war, declared or undeclared.
- (5) Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery) unless otherwise specified.
- (6) Routine services, unless otherwise specified and in accordance with federal law.
- (7) To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by the PPO Provider.
- (8) Expenses for which you have no legal obligation to pay in the absence of this or like coverage.
- (9) Charges for medical services received from a member of your Immediate Family.
- (10) Dental implants, considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic, unless if covered in the "Dental Services for an Accidental Injury" benefit.
- (11) Treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) surgery.
- (12) Treatment with intraoral prosthetic devises or by any other method, to alter vertical dimension.
- (13) Temporomandibular Joint Syndrome (TMJ) services.
- (14) Charges for any service or supply that is not Medically Necessary or does not meet the PPO Provider's policy, clinical coverage guidelines, or benefit policy guidelines.

- (15) Experimental or Investigational drugs, devices, medical treatments or procedures, unless otherwise specified.
- (16) Services or supplies that are for Outpatient educational, vocational or training purposes, except as may be required by PPACA.
- (17) Services and supplies for Custodial Care.
- (18) Services and supplies in excess of the most prevalent semi-private Hospital rate except as specifically provided by this Plan.
- (19) Services and supplies for Surgery to treat gender dysphoria or any treatment leading to or in connection with Surgery to treat gender dysphoria.
- (20) Any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy or LASIK (laser in situ keratomileusis).
- (21) Services and supplies as the result of an injury or illness caused by a contributed to by engaging in an assault or felony.
- (22) Services and supplies for dietary and/or nutritional counseling or training, unless otherwise specified or required by PPACA.
- (23) Services and supplies for non-Covered Services or services specifically excluded in the text of this SPD.
- (24) Over the counter drugs, vitamins or herbal remedies, except for certain preventive drugs written with a Physician's prescription and required by PPACA.
- (25) Services and supplies for treatment by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss, except as specified.
- (26) Treatment for infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT).
- (27) Services and supplies for weight loss surgery and any repairs, revisions or modifications of such surgery, including weight loss device removal.
- (28) Services and supplies not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
- (29) Services and supplies not performed within the scope of the Provider's license.

- (30) Services and supplies for which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, except, as specified elsewhere in this SPD or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, the Claims Administrator will calculate benefits as if he or she had enrolled.
- (31) Services and supplies received in a military facility for a military service related Condition.
- (32) Services or supplies for the removal of tattoos.
- (33) Services or supplies for arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flatfeet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, and toenails.
- (34) Services and supplies for massotherapy or massage therapy.
- (35) Services and supplies for hypnosis or acupuncture.
- (36) Charges for missed appointments, completion of claim forms or copies of medical records.
- (37) Charges for Gene Therapy Treatment.
- (38) Services and supplies received from other than a Provider.
- (39) Services and supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- (40) Services and supplies for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
- (41) Expenses incurred after you stop being a Covered Person unless otherwise specified in the Benefits After Termination of Coverage section.
- (42) Services or supplies for the following:
  - a. Physical examinations or services required by an insurance company to obtain insurance;
  - b. Physical examinations or services required by a governmental agency such as the FAA and DOT;
  - c. Physical examinations or services required by an employer in order to begin or to continue working;
  - d. Premarital examinations.

- (43) Services or supplies for court-ordered testing or care unless Medically Necessary.
- (44) Services or supplies for X-ray examinations with no preserved film image or digital record.
- (45) Services or supplies for Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.
- (46) Services or supplies for treatment of Conditions related to autism and other pervasive developmental disorders, intellectual disabilities, or behavioral problems.
- (47) Services or supplies for routine minor non-operative endoscopic procedures, other than coverage for colonoscopy and sigmoidoscopy required by PPACA.
- (48) Services or supplies for nutritional supplements.
- (49) Services or supplies for treatment of gynecomastia (male breast enlargement).
- (50) Services or supplies for sclerotherapy.
- (51) Services or supplies for marital counseling, unless otherwise specified.
- (52) Services or supplies for the medical treatment of sexual problems not caused by a biological Condition.
- (53) Services or supplies for male Contraceptives and over-the-counter birth control without a prescription.
- (54) Services or supplies for reverse sterilization.
- (55) Services or supplies for elective abortions.
- (56) Services or supplies for treatment of vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
- (57) Services or supplies for personal hygiene and convenience items.
- (58) Services or supplies for blood which is available without charge.
- (59) Services or supplies for outpatient blood storage services.
- (60) Services or supplies for specialized camps.
- (61) Services or supplies for water aerobics.

- (62) Services or supplies for After Hours Care.
- (63) Services or supplies for telephone consultations or consultations via electronic mail, facsimile or internet/website, except as required by law, authorized by the Claims Administrator, or otherwise described in this SPD.
- (64) Services or supplies for stand-by charges of a Physician.
- (65) Services or supplies for any Charges not documented in Provider records.
- (66) Services or supplies for fraudulent or misrepresented claims.
- (67) Services or supplies for charges for doing research with Providers not directly responsible for your care.
- (68) Services or supplies for a particular health service in the event that a Provider waives Copayments, Coinsurance (and/or the Deductible per Benefit Period); in such event, no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived.

**G. Preauthorization**

Preauthorization involves a decision by your plan and/or PPO Provider that a health care service, treatment plan, prescription drug or Durable Medical Equipment is medically necessary. This is also referred to as “precertification” or “prior approval.” The Plan requires preauthorization before you are admitted as an Inpatient in a Hospital or before you receive certain services as determined by the PPO Provider, except for an Emergency Medical Condition. Preauthorization is not a promise your plan will cover the cost. The PPO Provider maintains a list of services requiring preauthorization. If you need further information as to the services requiring preauthorization, please contact the Fund Office or the PPO Provider, and you will be provided a list of services requiring preauthorization.

**VI. HEALTH REIMBURSEMENT ARRANGEMENT  
(FROZEN AS OF JANUARY 14, 2017)**

The Trustees have established a health reimbursement arrangement (“HRA”) under the Insulators Local 84 Health Care Plan (“Health Care Plan”), which was subsequently frozen as of January 14, 2017. Participants are not currently eligible to receive disbursements from their Health Reimbursement Arrangement (“HRA”). If and when the HRA is reinstated, the following terms and conditions will apply:

**A. Purpose of HRA**

The purpose of the HRA is to provide medical care reimbursements for each Participant and his or her Eligible Dependents. It is the intention of the Board of Trustees that—

- (1) this HRA qualify as a health reimbursement arrangement within the meaning of Internal Revenue Service Notice 2002-45, 2002-28 I.R.B. 93, and an accident and health plan within the meaning of Code Section 105; and
- (2) the benefits payable under the HRA be eligible for exclusion from gross income under Code Section 105.

**B. Plan Year**

The Plan Year for the HRA shall be the same as the Plan Year for the Health Care Plan.

**C. Funding Medium for the Accumulation of Plan Assets**

Assets are accumulated and benefits are provided directly by the Trust Fund of the Health Care Plan. The principal and income of the HRA are to be used for the exclusive benefit of Participants and their Eligible Dependents, and for defraying proper expenses of administering the HRA.

**D. HRA's Effective Date**

The HRA was originally effective date July 1, 2006 but was subsequently frozen January 14, 2017.

**E. Sources of Contributions to the HRA**

Contributions to the HRA are made solely by Employers in accordance with the terms and conditions of the HRA and such other requirements as the Board of Trustees may determine. Employer Contributions to the HRA shall be made to the Trust Fund only under the obligations of a Collective Bargaining Agreement and/or other written agreement between a contributing Employer and the Union. The Union shall be the authority for the specific provisions of the collective bargaining agreement establishing the obligation of an Employer to make contributions.

**F. Incorporation of Other Plan Documents**

All definitions, terms, conditions and provisions of the Health Care Plan are adopted and made a part of this HRA unless the context otherwise indicates. Any questions, interpretations and disputes concerning eligibility for and amount of benefits shall be resolved by the Trustees in their sole discretion, and their decision shall be final, binding and conclusive.

**G. Initial Eligibility for HRA Benefits**

You are eligible to participate in and receive benefits from the HRA if you:

- (1) are an Employee; and
- (2) have a Credit Account with a positive balance; and

- (3) become eligible for comprehensive medical benefits coverage under Article V, Section A, above as of the time of the HRA contribution or thereafter. (For any contributions received to your HRA Account prior to you becoming eligible for comprehensive medical benefits coverage under Article V, Section A, above, you will not be able to use such HRA Account contributions until you do become eligible for comprehensive medical benefits coverage).

Your Credit Account is funded exclusively through Employer Contributions.

#### **H. Continuation of Eligibility**

You will continue to remain eligible for participation in the HRA as long as you have a positive balance in your Credit Account and are an Employee. Once the money in your Credit Account is exhausted, you are ineligible for benefits until your coverage is reinstated when you again satisfy the requirements for initial eligibility in the same manner as a new Employee.

#### **I. Termination of Eligibility**

Your coverage under the HRA will end on the earlier of the following:

- (1) the first day of the month following the twelve (12) consecutive month period during which your Credit Account begins at \$0 and remains at \$0 for the duration of such period; or
- (2) the day the HRA is terminated.

#### **J. Reinstatement of Eligibility after Termination**

If you terminate your coverage pursuant to I. above, your coverage will be reinstated when you again satisfy the requirements for initial eligibility in the same manner as a new Employee.

#### **K. Change of Eligibility Rules**

The Trustees, in their sole discretion, may change or amend the foregoing rules of eligibility or the benefits provided by this HRA at any time and for any reason.

#### **L. HRA Benefits**

Eligible Participants are entitled to reimbursement from their Credit Account for any itemized medical bills submitted for payment that:

- (1) are not covered by any other health insurance plan under which the Participant is covered;
- (2) relate to expenses for medical care incurred by the Participant or an Eligible Dependent after his or her commencement of participation in the HRA; and

- (3) satisfy the requirements for amounts paid to an individual as reimbursement for medical care expenses under Code Section 213(d).

Examples of eligible medical care expenses are medical bills, pharmaceutical bills, vision and/or dental co-pays, premiums and deductibles. Certain over-the-counter medications that are purchased for the diagnosis, cure, mitigation, treatment, or prevention of disease are also eligible for reimbursement. Expenses for items that are merely beneficial to your general health are not eligible for reimbursement. Examples of ineligible expenses are vitamins, dietary supplements, herbal remedies, toiletries, cosmetics, and sundry items.

A Participant may also use his or her Credit Account balance to maintain eligibility under the Health Care Plan.

**M. Limit on Benefits**

No Participant shall be entitled to receive reimbursements under this HRA in excess of the amount in his or her Credit Account.

**N. Eligibility for Reimbursement or Payment from Other Source**

Reimbursement under this HRA shall be made only in the event, and to the extent, that reimbursement for amounts expended, or payment, for medical care is not provided through any insurance policy or under any other plan in which the Employee is a Participant or under any federal or state law. If there is such a policy, plan or law in effect providing for such reimbursement or payment, in whole or in part, then, to the extent of the coverage under such policy, plan or law, the Trustees shall be relieved of any and all liability hereunder for reimbursement of the amounts expended or paid for medical care.

**O. Procedure For Filing An HRA Claim**

Except as otherwise provided herein, claims procedures under the HRA shall be governed by Article VII of the Health Care Plan.

To file an HRA claim, you must first obtain claim forms from the Union Office at: International Association of Heat and Frost Insulators and Allied Workers Local No. 84, 277 Martinel, Kent Ohio 44240. You may also obtain claim forms from the Third Party Administrator at: BeneSys, Inc., 33 Fitch Boulevard, Austintown, OH 44515 (Phone: (330) 779-8884; Fax: (330) 270-0912)

All sections of the claim form must be completed carefully and accurately, signed, dated and filed with the Third Party Administrator within one (1) year after the charge is incurred, along with an itemized bill for all expenses incurred.

Claims filed after the filing deadline will be considered only if there was reasonable cause for failure to timely file the claim, as determined by the Trustees in their sole discretion. If proof of a claim cannot be furnished to the Third Party Administrator by the filing deadline, the claim will not be

denied or reduced if proof is furnished as soon as reasonably possible. Unless you are legally incapacitated, failure to file the claim within two (2) years after the charge is incurred will invalidate the claim or reduce benefits, as determined by the Trustees, in their sole discretion.

A decision as to the validity of the claim will be made as promptly as possible after the claim is received, with necessary documentation. If a delay occurs, you will be notified of the reasons for the delay, as well as the anticipated length of the delay, in writing. If further information or other material is required, you will also be informed.

All reimbursements payable under the HRA shall be paid as soon as practicable after the end of the calendar quarter in which the necessary claim form is received by the Third Party Administrator. However, if your claim totals \$200 or more, the Third Party Administrator may pay your reimbursement sooner, upon request. If the amount of your claim exceeds your Credit Account balance when you file the claim, you will be reimbursed in an amount not exceeding your Credit Account balance. If you wish to be reimbursed for the remaining portion of your claim, you may file an additional claim when your Credit Account again has a positive balance, as long as your additional claim is filed by the filing deadline applicable to the original claim.

In order for the HRA to pay a claim, you must provide proof that you have actually incurred an expense for medical care which meets the requirements of this Article and proof of the exact amount of the medical care expense. You must honor any reasonable request for further information or for a repayment agreement. Otherwise, the HRA will not be able to pay your claim.

If the Third Party Administrator questions whether a claim should be paid or whether the services provided to you were unreasonably priced, the Third Party Administrator has the right to rely on the Health Care Plan's advisors for the decision.

#### **P. Claimant Payment**

All claim payments will be made to you and/or your Eligible Dependent. However, if you and/or your Eligible Dependent are: (1) deceased; or (2) a minor (under 18 years of age); or (3) in the Board of Trustees' opinion, not legally competent, then the Board of Trustees may make payment to you or another Eligible Dependent, as applicable, or to a service provider on behalf of you and an Eligible Dependent.

#### **Q. Change in Terms**

The terms of this HRA may be changed at any time without advance notice to you, except as prohibited by law. All changes in benefits will be made on a uniform basis, affecting similarly situated Participants and Employees equally, and will not apply to claims incurred before the amendment is effective.

#### **R. Administrative Charges and Earnings**

Individual Credit Accounts of Participants may be assessed a quarterly service charge to cover the costs of account administration. The amount charged to each Credit Account shall be determined

from time to time by a majority vote of the Trustees. The amount charged shall reasonably reflect the pro-rata cost of administering accounts. Individual Credit Accounts of Participants shall be credited with earnings. Any such earnings shall be credited semiannually.

**S. Right to Opt Out of HRA Account**

After termination of your medical coverage, you may not be entitled to a premium tax credit from the government for the purchase of health insurance from a health insurance exchange unless you permanently opt out of and waive further reimbursements from your HRA Account. Accordingly, upon termination of your coverage under the major medical Plan sponsored by the Insulators Local 84 Health Care Plan, you are permitted to permanently opt out of and waive future reimbursement from your HRA Account. Please contact the Fund Administrator to obtain the necessary waiver form.

**T. Health Reimbursement Arrangement Suspended Effective January 14, 2017**

Sections A through S of Article VI above are suspended effective January 14, 2017. The Plan will continue to track contributions to the Health Reimbursement Arrangement Accounts, but Participants will no longer be eligible to obtain any benefit or health care reimbursement from these accounts until further notice from the Plan.

**VII. DEFINITIONS**

**A. Accident**

“Accident” shall mean any accidental bodily injury which requires treatment by a physician and is recognized by the terms of the Plan and the Trustees.

**B. Administrator**

“Administrator” or “Fund Office” means BeneSys, Inc., whose contact information is located at the front of this SPD.

**C. After Hours Care**

“After Hours Care” means services received in a Physician’s office at times other than regularly scheduled office hours, including days when the office is normally (e.g. holidays or Sundays).

**D. Agreement and Declaration of Trust or Trust Agreement**

“Agreement and Declaration of Trust” or “Trust Agreement” means the Agreement and Declaration of Trust which has been entered into by and between the Union and the Association and those Employers who, by virtue of Collective Bargaining Agreements with the Union, have agreed to participate in and contribute to this Trust Fund and who became parties thereto and that document, as may from time to time be amended.

**E. Alcoholism**

“Alcoholism” means a Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as alcohol dependence, abuse or alcoholic psychosis.

**F. Allowed Amount**

“Allowed Amount” means for PPO Network and contracting providers, including Pharmacies, the lesser of the applicable negotiated amount or covered charge. “Allowed Amount” means, for non-contracting providers, including non-network pharmacies, the non-contracting amount which will likely be less than the billed charges.

**G. Association**

“Association” means the Master Insulators Association of Akron, Ohio, the Builders Association of Eastern Ohio and Western Pennsylvania, and any other group of Employers who negotiate with the Union to participate in the Trust Fund on behalf of themselves, other individual Employers on whose behalf they negotiate and/or Employers who make contributions into the Trust Fund pursuant to a collective bargaining agreement or written participation agreement with the Board of Trustees and any successors thereof.

**H. Autotransfusion**

“Autotransfusion” means the withdrawal and reinjection/transfusion of the patient’s own blood; only the patient’s own blood is collected on several occasions over time to be reinfused during an operative procedure in which substantial blood loss is anticipated.

**I. Benefit Period**

“Benefit Period” means the period of time specified in the Schedule of Benefits during which Covered Services are rendered and benefit maximums, Deductibles, and Out-of-Pocket Maximums are accumulated. The first and/or last Benefit Periods may be less than twelve (12) months, depending on the effective date and the date your coverage terminates.

**J. Billed Charges**

“Billed Charges” means the amount billed on the claim submitted by the Provider for services and supplies provided to a Covered Person.

**K. Brand Name Prescription Drug**

“Brand Name Prescription Drug” means a Prescription Drug that has been patented with a brand name and is produced by the original manufacturer under that brand name.

**L. Card Holder**

“Card Holder” means an Eligible Employee or member of the Group who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or any other legally mandated continuation of coverage.

**M. Charges**

“Charges” means the Provider’s list of charges for services and supplies before any adjustments for discounts, allowances, incentives or settlements. For a Contracting Hospital, charges are the master charge list uniformly applicable to all payors before any discounts, allowances, incentives or settlements.

**N. Child or Children**

“Child” or “Children” include a Participant’s natural sons and daughters, stepchildren, adopted children (including children placed for adoption), and foster children.

**O. Claimant**

“Claimant” means the person making the claim.

**P. Coinsurance**

“Coinsurance” means the percentage of the Allowed Amount or Non-Contacting Amount for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

**Q. Coinsurance Limit**

“Coinsurance Limit” means a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services.

**R. Collective Bargaining Agreement**

“Collective Bargaining Agreement” means any Collective Bargaining Agreement existing between an Employer and the Union which provides for contributions into the Trust Fund as well as any extension or extensions, renewal or renewals of any such Collective Bargaining Agreement or any Collective Bargaining Agreement which provides for contributions into this Trust Fund.

**S. Condition**

“Condition” means an injury, ailment, disease, illness or disorder.

**T. Contraceptives**

“Contraceptives” mean oral, injectable, implantable or transdermal patches for birth control.

**U. Contracting**

“Contracting” means the status of a Provider that has an agreement with the PPO Provider or the PPO Provider’s parent company about payment for Covered Services; or that is designated by the PPO Provider as Contracting.

**V. Copayment**

“Copayment” means a dollar amount, if specified in the Schedule of Benefits, that you are required to pay at the time Covered Services are rendered.

**W. Covered Charges**

“Covered Charges” means the billed charges for covered services, except that the PPO Provider reserves the right to limit the amount of covered charges for covered services provided by a non-contracting provider to the non-contracting amount determined as payable by the PPO Provider.

**X. Covered Person**

“Covered Person” means the Card Holder, and if family coverage is in force, the Card Holder’s Eligible Dependent(s).

**Y. Covered Service**

“Covered Services” means a Provider’s service or supply as described in this SPD for which the Plan will provide benefits, as listed in the Schedule of Benefits.

**Z. Credit Account**

“Credit Account” means the method of crediting Employer Contributions received on behalf of each Employee to the Employee’s individual Credit Account under the Health Care Plan. The cost of benefits plus the HRA’s administrative expenses shall be deducted from the Participant’s individual Credit Account.

**AA. Custodial Care**

“Custodial Care” means care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

- (1) administration of medication which can be self-administered or administered by a lay person; or
- (2) help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of a Condition.

**BB. Custodian**

“Custodian” means a person who, by court order, has permanent custody of a Child.

**CC. Deductible**

“Deductible” means an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits.

**DD. Drug Abuse**

“Drug Abuse” means a Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as drug dependence abuse or drug psychosis.

**EE. Eligible Dependent**

“Eligible Dependent” includes only the following:

- (1) An Eligible Employee’s legal Spouse, while not divorced or legally separated from the Eligible Employee.
- (2) All Children from birth to age twenty-six (26), regardless of marital status, work status, living status, financial dependency, or whether the Child is eligible for employer-based health care coverage under another health care plan. Grandchildren are not considered eligible dependents. No Child who is under age nineteen (19) shall be denied coverage under the Plan on account of a preexisting condition.
- (3) Regardless of age, an unmarried Child of the Eligible Employee who is dependent upon the Eligible Employee for primary support and maintenance because of a physical handicap or mental retardation as certified by a Physician. The Fund may request a statement indicating the extent of maintenance and support. For benefits to be effective, the physical handicap or mental retardation must have occurred before the unmarried Child reaches age twenty-six (26). If, however, an unmarried Child, on such unmarried Child’s termination date, is incapable of self-sustaining employment by reason of mental retardation or physical handicap and such incapacity commenced prior to the Limiting Age and such unmarried Child is primarily dependent upon the Eligible Employee for support and maintenance, the Plan will, subject to the conditions in the following paragraph, continue the health coverage for such unmarried Child so long as such Employee’s coverage remains in force and such incapacity continues, provided proof of such incapacity is submitted to the Board of Trustees within thirty-one (31) days of the date such Eligible

Dependent's coverage would otherwise terminate. For purposes of this paragraph (c), the Limiting Age is the unmarried Child's 26<sup>th</sup> birthday.

The Board of Trustees may require, at reasonable intervals during the two (2) years following the Child's attainment of the Limiting Age, subsequent proof of the unmarried Child's incapacity and dependency. After such two (2) year period, the Board of Trustees may require subsequent proof of incapacity and dependency of such unmarried Child once each year.

- (4) A Child above for whom an Eligible Employee is ordered by a United States court or administrative agency of competent jurisdiction to provide medical coverage in accordance with the provision of a Qualified Medical Child Support Order.

#### **FF. Eligible Employee, Covered Member or Covered Person**

"Eligible Employee," means a "Covered Member" or "Covered Person" who meets the Eligibility Rules as adopted by the Trustees and as set forth herein.

#### **GG. Emergency Medical Condition**

"Emergency Medical Condition" means a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn Child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of bodily organ or part of the individual.

#### **HH. Emergency Services**

"Emergency Services" mean a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

## **II. Employee**

"Employee" means and includes:

- (1) A Member of a Collective Bargaining Unit represented by the Union who is eligible to participate in and receive the benefits of the Health and Welfare Plan and Trust in accordance with the Agreement and Declaration of Trust; and

- (2) A full-time, regular Employee of the Union, the Trustees, the Fund Office and/or the Joint Apprenticeship Training Committee, subject to the review and approval of any conditions regarding contributions and participation imposed by the Trustees whose decision shall be final and binding; and
- (3) A full-time, non-seasonal, Employee of an Employer who is not a member of a Union Collective Bargaining Unit represented by the Union including, but not limited to, an officer, owner, partner, shareholder, manager, clerical worker, estimator, supervisor and any other full-time employee (hereinafter collectively referred to as “Nonbargaining Unit Employees”), but only if: (i) equal contributions are made for all Employees, (ii) all Employees receive equal benefits, (iii) all full-time Employees are covered under the Plan established hereunder, (iv) a Participation Agreement is entered into between the Employer and the Plan; and (v) subject to the review and approval of any other conditions regarding contributions and participation imposed by the Trustees. The Employer shall contribute to the Fund for all of its full-time, non-seasonal Employees subject to the non-discrimination requirements of applicable provisions of the Internal Revenue Code and the Regulations thereunder; and
- (4) An individual formerly employed by an Employer as a member of the Collective Bargaining Unit represented by the Union for purposes of allowing Self-Contribution direct payments to the Fund in accordance with the Rules and Regulations adopted by the Trustees and as set forth herein.

**JJ. Employer**

“Employer” means:

- (1) Any individual, firm, association, partnership or corporation who is a member of the Association and/or is represented in collective bargaining by the Association and who is bound by the Collective Bargaining Agreement with said Union, and in accordance therewith, agrees to participate in and contribute to the Trust Fund herein created and provided for; and
- (2) Any individual, firm, association, partnership or corporation who is not a member of nor represented in collective bargaining by the Association, but who has duly executed and/or is bound by the Collective Bargaining Agreement with said Union or signs a participation agreement with the Trust Fund and in accordance therewith agrees to participate in and contribute to the Trust Fund herein created and provided for; and
- (3) The Union, to the extent and solely to the extent that it acts in the capacity of an Employer of its Employees on whose behalf it makes contributions to the Trust Fund in accordance with the Collective Bargaining Agreement and/or a participation

agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and

- (4) The Trustees, to the extent that they act in the capacity of an Employer of their Employees on whose behalf they make contributions to the Trust Fund in accordance with the Collective Bargaining Agreement and/or participation agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and
- (5) The Joint Apprenticeship Training Committee to the extent, and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it makes Contributions to the Trust Fund pursuant to a Collective Bargaining Agreement and/or participation agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and
- (6) The Fund Office to the extent, and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it makes Contributions to the Trust Fund pursuant to a Collective Bargaining Agreement and/or participation agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and
- (7) The Employers, as defined herein, shall, by the making of payments to the Trust Fund pursuant to the Collective Bargaining Agreement and/or participation agreement, be conclusively deemed to have accepted and be bound by the Trust Agreement, the Collective Bargaining Agreement, this Plan, the Rules and Regulations and all actions of the Trustees.

**KK. Employer Contributions**

“Employer Contributions” means payments made to the Trust Fund by an Employer.

**LL. Essential Health Benefits**

“Essential Health Benefits” means benefits defined under federal law (The Affordable Care Act or “ACA” or “PPACA”) and accompanying regulations as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Refer to the Schedule of Benefits and the Health Care Benefits section of this SPD to identify which of these Essential Health Benefits are included in this Plan.

### **MM. Excess Charges**

“Excess Charges” means the difference between Billed Charges and the applicable Allowed Amount or Non-Contracting Amount. You may be responsible for Excess Charges when you receive services from a Non-Contracting Provider or a non-Network Pharmacy.

### **NN. Experimental or Investigational Drug, Device, Medical Treatment or Procedure**

A “drug,” “device,” “medical treatment” or “procedure” is “Experimental” or “Investigational:”

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing phase I, II or III clinical trials, or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and that the further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence may consist of any one or more of the following:

- published reports and articles in the authoritative medical and scientific literature;
- opinions expressed by expert consultants retained by the Plan or PPO Provider to evaluate request for coverage;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure;
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;
- corporate medical policies developed by the PPO Provider; or
- any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations.

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, the Plan will cover those medically necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that the Plan would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by the Trustees and the PPO Provider in their sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

**OO. Formulary Brand Name Prescription Drug**

“Formulary Brand Name Prescription Drug” means a Brand Name Prescription Drug that the Plan’s prescription drug benefit administrator has listed among preferred brand-name products in each of a number of therapeutic categories.

**PP. Generic Prescription Drug**

“Generic Prescription Drug” means a Prescription Drug that is produced by more than one manufacturer. It is chemically the same as and usually costs less than the Brand Name Prescription Drug for which it is being substituted.

**QQ. Health and Welfare Plan or Health Care Plan**

“Health and Welfare Plan” or “Health Care Plan” means the Insulators Local 84 Health Care Plan, as the Health Care Plan may, from time to time, be amended as well as any plan, program, methods and procedure for the payment of benefits from the Trust Fund (directly or indirectly) adopted by the Trustees in accordance with such eligibility requirements as the Trustees may, from time to time, adopt and promulgate, and as set forth herein.

**RR. Hospital**

“Hospital” means an accredited Institution that meets the specifications set forth in the appropriate Chapter of the Ohio Revised Code and any other regional, state or federal licensing requirements, except for the requirement that such Institution be operated within the State of Ohio.

**SS. HRA**

“HRA” means the health reimbursement arrangement provided to Participants under the Health Care Plan as provided herein.

**TT. Illness**

“Illness” means a sickness or disease (including mental health) which requires treatment by a doctor and is recognized by the terms of this Plan and the Trustees.

**UU. Immediate Family**

“Immediate Family” means the Participant and the Participant’s spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren by blood, marriage or adoption.

**VV. Incurred**

“Incurred” means rendered to you by a Provider. All services rendered by the Institutional Provider during an Inpatient admission prior to termination of coverage are considered to be Incurred on the date of admission.

**WW. Injury**

“Injury” means any accidental bodily injury which requires treatment by a physician and is recognized by the terms of this Plan and the Trustees. Determination of whether Injuries are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

**XX. Inpatient**

“Inpatient” means a Covered Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a room and board charge is made.

**YY. Institution (Institutional)**

“Institution” or “Institutional” means a Hospital or Other Facility Provider.

**ZZ. Mail Order Prescription Drug**

“Mail Order Prescription Drug” means a Prescription Drug which can be provided through a mail service program.

**AAA. Medical Care**

“Medical Care” means Professional services received from a Physician or Other Professional Provider to treat a condition.

**BBB. Medically Necessary or Medical Necessity**

“Medically Necessary” or “Medical Necessity” means a Covered Service,” supply and/or Prescription Drug that is required to diagnose or treat a Condition and which the Claims Administrator determines is:

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- not primarily for your convenience or the convenience of a Provider; and
- the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug

is cost effective compared to alternative prescription drugs which will produce comparable effective clinical results.

**CCC. Medicare**

“Medicare” means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

**DDD. Medicare Approved**

“Medicare Approved” means the status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

**EEE. Mental Illness**

“Mental Illness” means a Condition classified as a mental disorder in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9CM) or the most recent version, excluding Drug Abuse and Alcoholism.

**FFF. Negotiated Amount**

“Negotiated Amount” means the amount the Provider has agreed with the PPO Provider or the Pharmacy Benefit Manager to accept as payment in full for Covered Services, subject to the limitations set forth below:

The Negotiated Amount may include performance withholds and/or payments to Providers for quality or wellness incentives that may be earned and paid at a later date. Your Copayment, Deductible, and/or Coinsurance amounts may include a portion that is attributable to a quality incentive payment or bonus and will not be adjusted or changed if such payments are not made.

The Negotiated Amount for Providers does not include adjustments and/or settlement due to the prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitations violations, performance withhold adjustments or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim. In addition, the Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings (rebates), volume-based credits or refunds or discount guarantees.

In certain circumstances, the PPO Provider may have an agreement or arrangement with a vendor which purchases the services, supplies or products from the Provider instead of the PPO Provider contracting directly with the Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement the PPO Provider has with the vendor and not upon the vendor’s actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

**GGG. Non-Contracting**

“Non-Contracting” means the status of a Provider that does not have a contract with the PPO Provider or one of its networks.

**HHH. Non-Contracting Amount**

“Non-Contracting Amount” means, subject to applicable law, the maximum amount allowed by the PPO Provider for Covered Services provided to Covered Persons by a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the Provider’s Billed Charges. If you receive service from a Non-Contracting Provider, and you are balanced billed for the difference between the Non-Contracting Amount and the Billed Charges, you may be responsible for the full amount up to the Provider’s Billed Charges, even if you have met your Out-of-Pocket Maximum.

**III. Non-Covered Charges**

“Non-Covered Charges” means Billed Charges for services and supplies that are not Covered Services.

**JJJ. Non-Formulary Brand Name Prescription Drug**

“Non-Formulary Brand Name Prescription Drug” means a Brand Name Prescription Drug that the Plan’s prescription drug benefit administrator has not listed among preferred brand-name products in each of a number of therapeutic categories.

**KKK. Non-Occupational**

“Non-Occupational” means, with respect to illness or injury, any illness or injury which is not covered under any Workers’ Compensation, the Veteran’s Department of Affairs or similar statutes.

**LLL. Office Visit**

“Office Visit” includes medical visits or Outpatient consultations in a Physician’s office or patient’s residence. A Physician’s office can be defined as a medical/office building, Outpatient department of a Hospital, freestanding clinic facility or a Hospital-based Outpatient clinic facility.

**MMM. Other Facility Provider**

“Other Facility Provider” means the following institutions that are licensed, when required, and where covered services are rendered that require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. The Plan will only provide benefits for services or supplies for that a charge is made. Only the following institutions that are defined below are considered Other Facility Providers:

- Alcoholism Treatment Facility – a facility that mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- Ambulatory Surgical Facility – a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a physician and also includes nursing services.
- Day/Night Psychiatric Facility – a facility that is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.
- Dialysis Facility – a facility that mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- Drug Abuse Treatment Facility – a facility that mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.
- Home Health Care Agency – A facility that meets the specifications set forth in the appropriate Chapter of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and that provides nursing and other services as specified in the Home Health Care Services section of this SPD. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- Hospice Facility – a facility that provides supportive care for patients with a reduced life expectancy due to advanced illness as specified in the Hospice Services section of this SPD.
- Psychiatric Facility – a facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.
- Psychiatric Hospital – A facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of mental illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.
- Skilled Nursing Facility – a facility that primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a physician.

**NNN. Other Professional Provider**

“Other Professional Provider” means only the following persons or entities which are licensed as required:

- (1) Advanced Nurse Practitioner (A.N.P.);
- (2) Ambulance Services;
- (3) Certified Dietician;
- (4) Certified Nurse Practitioner;
- (5) Clinical Nurse Specialist;

- (6) Dentist;
- (7) Doctor of Chiropractic Medicine;
- (8) Durable Medical Equipment or Prosthetic Appliance Vendor;
- (9) Laboratory (must be Medicare Approved);
- (10) Licensed Independent Social Workers (L.I.S.W.);
- (11) Licensed Practical Nurse (L.P.N.);
- (12) Licensed Professional Clinical Counselor;
- (13) Licensed Professional Counselor;
- (14) Licensed Vocational Nurse (L.V.N.);
- (15) Mechanotherapist (licensed or certified prior to November 3, 1975);
- (16) Nurse-Midwife;
- (17) Occupational Therapist;
- (18) Ophthalmologist;
- (19) Optometrist;
- (20) Osteopath;
- (21) Pharmacy;
- (22) Physical Therapist;
- (23) Physician Assistant;
- (24) Podiatrist;
- (25) Psychologist;
- (26) Registered Nurse (R.N.);
- (27) Registered Nurse Anesthetist; and
- (28) Urgent Care Provider.

Covered Services provided by Providers not listed here will also be considered for reimbursement if the Provider is acting within the scope of his or her license or certification under state law.

**OOO. Out-of-Pocket Maximum**

“Out-of-Pocket Maximum” means a specified dollar amount of Deductible, Coinsurance and Copayment expense Incurred in a Benefit Period by a Covered Person for Covered Services.

**PPP. Outpatient**

“Outpatient” means the status of a Covered Person who receives services or supplies through a Hospital, Other Facility Provider, Physician or Other Professional Provider while not confined as an inpatient.

**QQQ. Participant**

“Participant” means any Employee or former Employee of an Employer or any member or former member of the Union who is or may become eligible to receive a benefit of any type from the Trust Fund, or whose Beneficiaries may be eligible to receive any such benefit. All Card Holders are considered Participants.

**RRR. Pharmacy**

“Pharmacy” means an Other Professional Provider that is licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

**SSS. Physician**

“Physician” means a person who is licensed and leally authorized to practice medicine.

**TTT. Plan**

“Plan” means the Insulators Local 84 Health Care Plan, as the Plan may, from time to time, be amended as hereinafter provided.

**UUU. PPACA**

“PPACA” means the Patient Protection and Affordable Care Act.

**VVV. PPO Network**

“PPO Network” means a limited panel of Providers as designated by the PPO Provider known as a preferred provider organization.

**WWW. PPO Provider**

“PPO Provider” means the entity with which the Board of Trustees has currently contracted to provide medical claim management discounts. The PPO Provider is also the “Claims Administrator” responsible for adjudicating medical claims.

**XXX. Preauthorization**

“Preauthorization” means a decision made by the PPO Provider that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. This is also referred to as “precertification” or “prior approval.” Preauthorization is required before you are admitted as an Inpatient in a Hospital or before you receive certain services, except for an Emergency Medical Condition. Preauthorization is not a promise that the Plan will cover the cost.

**YYY. Prescription Drug (Federal Legend Drug)**

“Prescription Drug” or “Federal Legend Drug” means any medication that by federal or state law may not be dispensed without a Prescription Order.

**ZZZ. Prescription Drug Order**

“Prescription Drug Order” means the request for medication by a Physician or Other Professional Provider who is licensed by his or her state to make such a request in the ordinary course of Professional practice.

**AAAA. Professional**

“Professional” means a Physician or Other Professional Provider.

**BBBB. Professional Charges**

“Professional Charges” means the cost of a Physician or Other Professional Provider’s services before the application of the Negotiated Amount.

**CCCC. Provider**

“Provider” means a Hospital, Other Facility Provider, Physician or Other Professional Provider.

**DDDD. Psychologist**

“Psychologist” means an Other Professional Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

**EEEE. Residential Treatment Facility**

“Residential Treatment Facility” means a facility that meets all of the following:

- (1) An accredited facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders who do not require care in an acute or more intensive medical setting.
- (2) The facility must provide room and board as well as providing an individual treatment plan for the chemical, psychological and social needs of each of its residents.
- (3) The facility must meet all regional, state and federal licensing requirements.
- (4) The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers.

**FFFF. Routine Services**

“Routine Services” means services not considered Medically Necessary.

**GGGG. Sickness**

“Sickness” means an illness or disease (including mental disorders) which requires treatment by a Provider and is recognized by the terms of this Plan and the Trustees. Sickness shall include pregnancy, childbirth or miscarriage.

**HHHH. Skilled Care**

“Skilled Care” means care that requires the skill, knowledge or training of a Physician or a registered nurse; licensed practical nurse; or physical therapist performing under the supervision of a Physician. In the absence of such care, the Covered Person’s health would be seriously impaired. Such care cannot be taught to or administered by a lay person.

**IIII. Specialist**

“Specialist” means a Physician or group of Physicians, in other than family practice, general practice, geriatrics, internal medicine, pediatrics, neonatology, obstetrics, gynecology, or advanced practice nurses.

**JJJJ. Spouse**

“Spouse” or “spouse” means that person, if any, who:

- (1) is recognized as legally married to the Participant by a domestic or foreign jurisdiction whose laws authorized the marriage at the time the Participant and such person entered into the marital relationship; and
- (2) has not been declared legally separated from the Participant by any judicial order.

**KKKK. Stabilize**

“Stabilize” means with respect to an Emergency Medical Condition, to provide such medical treatment of the Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the Condition is likely to result from or occur during the transfer of the individual from a facility.

**LLLL. Substance Abuse**

“Substance Abuse” means Alcoholism and/or Drug Abuse.

**MMMM. Surgery**

“Surgery” means the performance of generally accepted operative and other invasive procedures; or the correction of fractures and dislocations; or usual and related preoperative and postoperative care; or other procedures as reasonably approved by the PPO Provider.

**NNNN. Total Disability or Totally Disabled**

“Total Disability” or “Totally Disabled,” unless otherwise specifically defined, means as a direct result of an Injury or Illness, the Participant is unable to:

- (1) In the case of an Eligible Employee during the first twelve (12) months of such disability, perform the material and substantial duties of the occupation of the Eligible Employee at the onset of the disability; or
- (2) In the case of an Eligible Employee during the period after the first twelve (12) months of such disability, perform the material and substantial duties of any occupation for which the Eligible Employee is qualified by education, training or experience which provides other health insurance coverage; or
- (3) In the case of an Eligible Dependent, perform the normal substantial activities of a person of like age and sex in good health.

Determination of whether an Eligible Employee or an Eligible Dependent is Totally Disabled or Total Disability will be made by the Trustees in their sole discretion and will be conclusive.

**OOOO. Transplant Center**

“Transplant Center” means a facility approved by the PPO Provider that is an integral part of a Hospital and that:

- (1) has consistent, fair and practical criteria for selecting patients for transplants;
- (2) has a written agreement with an organization that is legally authorized to obtain donor organs; and
- (3) complies with all federal and state laws and regulations that apply to transplants covered by the Plan.

**PPPP. Trust Fund, Trust or Fund**

“Trust Fund,” “Trust” or “Fund” means the Insulators Local 84 Health Care Fund and the entire assets thereof, including all funds received by the Trustees in the form of Employer contributions, together with all contracts (including dividends, interest, refunds and other sums payable to the Trust Fund on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits therefrom, and any and all other property of funds received and held by the Trustees under the Trust Agreement.

**QQQQ. Trustee**

“Trustee” means any natural person designated as Trustee under the terms of the original Agreement and Declaration of Trust and his or her successor or successors in office. The Trustees, collectively, shall be the “Administrator,” as that term is used under ERISA.

**RRRR. Union**

“Union” means International Association of Heat & Frost Insulators & Allied Workers, Local 84 and its successors.

**SSSS. United States**

“United States” means all the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam and the Northern Mariana Islands.

**TTTT. Urgent Care**

“Urgent Care” means any Condition which is not an Emergency Medical Condition that requires immediate attention.

**UUUU. Urgent Care Provider**

“Urgent Care Provider” means an Other Professional Provider that performs services for health problems that require immediate medical attention that are not Emergency Medical Conditions.

**VIII. HEALTH CARE BENEFITS**

This Article IX describes the services and supplies covered if provided and billed by Providers. All Covered Services must be Medically Necessary unless otherwise specified.

**Please refer to the Prior Approval of Non-PPO Network Benefits in the How Claims Are Paid section of the General Provisions for Information regarding services received from Non-PPO Providers.**

**Women’s Health and Cancer Rights Act Notice**

Your Plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Customer Service number located on your identification card for more information.

**A. Alcoholism and Drug Abuse Services**

Benefits are provided for the treatment of Alcoholism and Drug Abuse. Covered services include:

- Inpatient treatment, including rehabilitation and treatment in a Residential Treatment Facility;
- Outpatient treatment, including partial Hospitalization and intensive Outpatient services;

- Detoxification services;
- Individual and group psychotherapy;
- Psychological testing; and
- Counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under the Plan. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient receiving treatment for Alcoholism or Drug Abuse.

Inpatient admissions to a Hospital Provider or Residential Treatment Facility must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Providers in Ohio will assure this preauthorization is done; and since the Provider is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For Non-Contracting Providers or Providers outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize these admissions and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

#### **B. Allergy Tests and Treatments**

Allergy tests and treatment that are performed and related to a specific diagnosis are Covered Services.

#### **C. Ambulance Services**

Transportation for Conditions other than Emergency Medical Conditions via ambulance must be certified by your Physician. Transportation services are subject to medical review to determine Medical Necessity. Ambulance services include local ground transportation by a vehicle equipped and used only to transport the sick and injured:

- From your home scene of an accident or Emergency Medical Condition to a Hospital;
- Between hospitals;
- Between a Hospital and a Skilled Nursing Facility;
- From a Hospital or Skilled Nursing Facility to your home; or
- From a Physician's office to a Hospital.

Trips must be to the closest facility that is medically equipped to provide the Covered Services that are appropriate for your Condition.

Transportation for Emergency Medical Conditions will also be covered when provided by a professional ambulance service for other than local ground transportation such as air and water transportation, only when special treatment is required, and the transportation is to the nearest Hospital qualified to provide the special treatment.

**Transportation services provided by an ambulette or a wheelchair van are not Covered Services.**

**D. Case Management**

Case management is an economical, common-sense approach to managing health care benefits. The Claims Administrator's case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and Substance Abuse treatment. In such instances, benefits not expressly covered under this SPD may be approved. All case management programs are voluntary for the patient.

Coverage for these services must be approved in advance and in writing by the Claims Administrator. To learn more about these services, you may contact the Claims Administrator's case management staff.

**E. Clinical Trial Programs**

Benefits are provided for Routine Patient Costs administered to a Covered Person participating in any stage of an Approved Clinical Trial if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial.

In order to be eligible for benefits, the Covered Person must meet the following conditions:

- (1) The Covered person is eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.
- (2) Either:
  - a) The referring Provider is a PPO Network Provider and has concluded that the Covered Person's participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above; or
  - b) The Covered Person provides medical and scientific information establishing that his or her participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above.

If the clinical trial is not available from a PPO Network Provider, the Covered Person may participate in an Approved Clinical Trial administered by a Non-Contracting Provider. However, the Routine Patient Costs will be covered at the Non-Contracting Amount, and the Covered Person may be subject to balance billing up to the Provider's Billed Charges for the services.

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or Condition and is described in any of the following:

- A federally funded trial.
- The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.

- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

“Life-threatening Condition” means any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

“Routine Patient Costs” means all health care services that are otherwise covered under the Plan for treatment of cancer or other Life-threatening Condition that is typically covered for a patient who is not enrolled in an Approved Clinical Trial.

“Subject of a Clinical Trial” means the health care service, item or drug that is being evaluated in the Approved Clinical Trial and that is not a Routine Patient Cost.

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by an entity other than The Plan, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

#### **F. Dental Services for an Accidental Injury**

Dental services will only be covered for initial injuries sustained in an accident. The accidental injury must have caused damage to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury. This exclusion for injuries as a result of biting or chewing shall not apply if such injury was the result of domestic violence or if an underlying medical Condition caused the biting or chewing-related injuries. For example, a Covered Person with epilepsy involuntarily clamps down on his teeth and breaks one during a seizure. The underlying Illness must cause the chewing or biting accident that results in injury to the jaws, sound natural teeth, mouth or face. If a Covered Person has an underlying Illness that causes the teeth to be more susceptible to injury, dental services related to such injury will not be covered as an injury sustained in an accident.

Coverage may be provided for dental implants only when due to trauma, accidents, or when deemed medically necessary by the Plan.

## **G. Diagnostic Services**

A diagnostic service is a test or procedure performed, when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Covered diagnostic services are limited to the following:

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology services; and
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

## **H. Drugs and Biologicals**

You are covered for Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service, such as antibiotics, joint injections and chemotherapy, in the course of the diagnosis or treatment of a Condition. Other drugs, subject to the exclusions and limitations of this SPD, will be covered under the Plan's Prescription Benefits provided in Section V(F) of this SPD.

## **I. Emergency Services**

You are covered for Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week. If you are experiencing an Emergency Medical Condition, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. **Care and treatment once you are Stabilized are not Emergency Services.** Continuation of care beyond that needed to evaluate or Stabilize your Emergency Medical Condition will be covered according to your Schedule of Benefits, as provided in this SPD.

## **J. Home Health Care Services**

The following are Covered Services when you receive them from a Hospital or a Home Health Care Agency:

- professional services or a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling patients; and
- home health aide visits when you are also receiving covered nursing or therapy services.

The Plan will not cover any home health care services or supplies which are not specifically listed in this Home Health Care Services section. Examples include but are not limited to:

- homemaker services;
- food or home delivered meals; and

- Custodial Care, rest care or care which is only for someone's convenience.

All Home Health Care services must be certified initially by your Physician and your Physician must continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Plan. All services will be provided according to your Physician's treatment plan and as authorized as Medically Necessary by the Claims Administrator.

## **K. Hospice Services**

Hospice services consist of health care services provided to a Covered Person who is a patient with a reduced life expectancy due to advanced illness. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

The following Covered Services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs; limited to a two-week supply per Prescription Drug Order or refill (These Prescription Drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care.);
- oxygen and its administration;
- medical social services, such as counseling patients;
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute Inpatient hospice services;
- respite care;
- dietary guidance;
- counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

**Non-Covered hospice services include, but are not limited to:**

- **volunteer services;**
- **spiritual counseling;**
- **homemaker services;**
- **food or home delivered meals;**
- **chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition; and**
- **Custodial Care, rest care or care which is only for someone's convenience.**

## **L. Inpatient Health Education Services**

Benefits are provided for educational, vocational and training services while an Inpatient of a Hospital or Other Facility Provider.

## **M. Inpatient Hospital Services**

The Covered Services listed below are benefits when services are performed in an Inpatient setting, unless otherwise specified.

The following bed, board and general nursing services are covered:

- a semiprivate room or ward;
- a private room, when Medically Necessary; if you request a private room, the Plan will provide benefits only for the Hospital's average semiprivate room rate;
- newborn nursery care; and
- a bed in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.

Covered ancillary Hospital services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;
- Prescription Drugs;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but Charges for the blood are excluded. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**
- anesthesia, anesthesia supplies and services;
- oxygen and other gases;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

**Non-covered Hospital services include, but are not limited to:**

- **gowns and slippers;**
- **shampoo, toothpaste, body lotions and hygiene packets;**
- **take-home drugs;**
- **telephone and television; and**
- **guest meals or gourmet menus.**

**Coverage is not provided for an Inpatient admission, the primary purpose of which is:**

- **diagnostic services;**
- **Custodial Care;**
- **rest Care;**
- **environmental change;**
- **physical therapy; or**
- **residential treatment (for conditions other than those related to Mental Health Care, Drug Abuse or Alcoholism).**

**Coverage for Inpatient care is not provided when the services could have been performed on an Outpatient basis, and it was not Medically Necessary, as determined by the Claims Administrator, for you to be an Inpatient to receive them.**

Inpatient admissions to a Hospital must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this preauthorization is done; and since the Hospital is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For Non-Contracting Hospitals or Hospitals outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize a Hospital admission and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges. However, if your Inpatient stay is for an organ transplant, please review the requirements under the Organ Transplant Services section.

#### **N. Inpatient Physical Medicine and Rehabilitation Services**

Coverage is provided for acute Inpatient care from a Provider for physical rehabilitation services received in a rehabilitation facility.

#### **O. Maternity Services**

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and routine nursery care for a well newborn are covered.

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum 48 hours for vaginal delivery and 96 hours for a caesarian section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. Please not that neither you nor your Provider is required to obtain prior approval of an Inpatient maternity stay that falls within these time frames.

Physician-directed, follow-up care services are covered after discharge including:

- parent education;
- physical assessments of the mother and newborn;
- assessment of the home support system;
- assistance and training in breast or bottle feeding;

- performance of any Medically Necessary and appropriate clinical tests; and
- any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

Covered Services will be provided whether received in a medical setting or through home health care visits. Home health care visits are only covered if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

If requested by the mother, coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending Physician or the nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
  - the antepartum, intrapartum, postpartum course of the mother and infant;
  - the gestational stage, birth weight and clinical condition of the infant;
  - the demonstrated ability of the mother to care for the infant after discharge; and
  - the availability of postdischarge follow up to verify the condition of the infant after discharge.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours stated above, at home post delivery follow up care visits are covered for you at your residence by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

- parent education;
- physical assessments;
- assessment of the home support system;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At the mother's discretion, this visit may occur at the facility of the Provider.

The Plan will cover Maternity Services as described in this SPD for you if you are acting as a surrogate. However, to the extent that you receive any compensation or payment from any third party, even if the compensation or payment is designated for services other than medical expenses, the Plan will retain the right to subrogate against that compensation to the extent that it pays for maternity claims under this Plan. You are obligated to notify the Claims Administrator of any compensation or payment you receive as a result of acting as a surrogate and the benefits payable

hereunder are contingent on your cooperation according to this provision. No coverage will be provided for maternity services Incurred by a person not covered under this Benefit Book who is acting as a surrogate for you or any Dependent.

**P. Medical Care**

- 1. Concurrent Care** – You are covered for care by two or more Physicians during one Hospital stay when you have two or more unrelated Conditions. You are also covered for care for a medical Condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.
- 2. Inpatient Consultation** – A bedside examination by another Physician or Other Professional Provider is covered when requested by your attending physician. If the consulting Physician takes charge of your care, consultation services are not covered. When this occurs, the consulting Physician is considered to be the new attending Physician. Coverage is not provided for both the new attending Physician and the Physician who was initially treating you for services rendered at the same time. Staff consultations required by Hospital rules are not covered.
- 3. Inpatient Medical Care Visits** – The examinations given to you by your Physician or Other Professional Provider is covered when requested by your attending Physician. If the Plan changes your health care benefits, causing an increase or decrease in your Inpatient Medical Care Visits allowed, the number of Inpatient Medical Care Visits already used will be deducted from the number of visits available under your new coverage.
- 4. Intensive Medical Care** – Constant medical attendance and treatment is covered when your Condition requires it.
- 5. Newborn Examination** – Your coverage includes the Inpatient Medical Care Visits to examine a newborn.
- 6. Office Visits** – Office Visits to examine, diagnose and treat a Condition are Covered Services.

**Q. Medical Supplies and Durable Medical Equipment**

Supplies and Durable Medical Equipment are covered if they serve a specific, therapeutic purpose in treatment of a condition.

- 1. Medical and Surgical Supplies** – Disposable supplies which serve a specific therapeutic purpose are covered. These include:
  - syringes;
  - needles
  - oxygen; and

- surgical dressings and other similar items.

**Items usually stocked in the home for general use are not covered. These include, but are not limited to:**

- elastic bandages;
- thermometers;
- corn and bunion pads; and
- jobst stockings and support/compression stockings.

2. **Durable Medical Equipment (DME)** – Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Upon request your Physician must provide a written treatment plan that shows how the prescribed equipment is Medically Necessary for the diagnosis or treatment of a Condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your Physician may be required to recertify that continued use is Medically Necessary.

**You may rent or purchase DME; however, for each Condition, the Plan will not cover more in total rental costs than the customary purchase price as determined by the Claims Administrator.** For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of Durable Medical Equipment.

When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME.

Covered DME includes:

- blood glucose monitors;
- respirators;
- home dialysis equipment;
- wheelchairs;
- hospital beds;
- crutches; and
- mastectomy bras.

**Non-covered equipment includes, but is not limited to:**

- **rental costs if you are in a facility which provides such equipment;**
- **repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;**
- **Physician's equipment, such as a blood pressure cuff or stethoscope;**

- **deluxe equipment such as specially designed wheelchairs for use in sporting events; and**
  - **items not primarily medical in nature such as:**
    - **an exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;**
    - **items for comfort and convenience;**
    - **disposable supplies and hygienic equipment;**
    - **self-help devices such as: bedboards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units;**
    - **other compression devices.**
- 3. Orthotic Devices** - Rigid or semirigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. These devices include:
- braces for the leg, arm, neck or back;
  - trusses; and
  - back and special surgical corsets.

**Non-covered orthotic devices include, but are not limited to:**

- **garter belts, arch supports, corsets and corn and bunion pads;**
  - **corrective shoes, except with accompanying orthopedic braces; and**
  - **arch supports and other foot care or foot support devices only to improve comfort or appearance. These include, but are not limited to care for flat feet and subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails.**
- 4. Prosthetic Appliances** - Your coverage includes the purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:
- replace all or part of a missing body organ or limb and its adjoining tissues; or
  - replace all or part of the function of a permanently useless or malfunctioning body organ or limb.

**Covered prosthetic appliances include:**

- intraocular lens implantation for the treatment of cataract, aphakia or keratoconus;
- soft lenses or sclera shells for use as corneal bandages when needed as a result of eye Surgery;
- artificial hands, arms, feet, legs and eyes, including permanent lenses; and
- appliances needed to effectively use artificial limbs or corrective braces; and
- mastectomy prosthetics.

**Non-covered prosthetic appliances include but are not limited to:**

- **dentures, unless as a necessary part of a covered prosthesis;**
- **dental appliances;**
- **eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;**
- **replacement of cataract lenses unless needed because of a lens prescription change;**
- **taxes included in the purchase of a covered prosthetic appliance;**
- **deluxe prosthetics that are specially designed for uses such as sporting events; and**
- **wigs and hair pieces.**

**R. Mental Health Care Services**

Covered Services for the treatment of Mental Illness include:

- Inpatient treatment, including treatment in a Residential Treatment Facility;
- Outpatient treatment, including partial Hospitalization and intensive Outpatient services;
- individual and group psychotherapy;
- electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- psychological testing;
- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Benefit Book. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient;
- In addition, as provided in the Claims Administrator's medical policy guidelines, certain behavioral assessment and intervention services for individual, family and group psychotherapy will also be covered for a medical Condition.

**Services for autism and intellectual disability, other than those necessary to evaluate or diagnose these Conditions, are not covered. Mental Illness which cannot be treated is not covered.** However, services to determine if the Mental Illness can be treated are covered. Services for the treatment of attention deficit disorder are covered.

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Providers in Ohio will assure this preauthorization is done; and since the Provider is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For Non-Contracting Providers or Providers outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize these admissions and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

## S. Organ Transplant Services

Your coverage includes benefits for the following Medically Necessary human organ transplants:

- bone marrow;
- cornea;
- heart;
- heart and lung;
- kidney;
- liver;
- lung;
- pancreas; and
- pancreas and kidney

Additional organ transplants will be considered for coverage provided that the transplant is Medically Necessary, not Experimental and is considered accepted medical practice for your Condition.

**Organ Transplant Preauthorization** - In order for an organ transplant to be a Covered Service, the proposed course of treatment and the Inpatient stay for the organ transplant must both be preauthorized by the Claims Administrator.

PPO Network Providers within the SuperMed Network and Contracting Hospitals in Ohio are responsible for obtaining preauthorization of the proposed course of treatment and the Inpatient stay.

If the Covered Person utilizes a Provider who is not a SuperMed Provider or utilizes a Hospital outside Ohio or that is a Non-Contracting Hospital, the Covered Person is responsible for obtaining preauthorization for both the proposed course of treatment and the Inpatient stay. If the organ transplant is not preauthorized and is determined to not be Medically Necessary, the Covered Person may be responsible for all Billed Charges for that organ transplant.

In addition, if the organ transplant is not preauthorized and is determined to be Experimental/Investigational, the Covered Person may be responsible for all Billed Charges for that organ transplant.

After your Physician has examined you, he must provide the Claims Administrator with:

- the proposed course of treatment for the transplant;
- the name and location of the proposed Transplant Center; and
- copies of your medical records, including diagnostic reports for the Claims Administrator to determine the suitability and Medical Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ. You may also be required to undergo an examination by a Physician chosen by the Claims Administrator. You and your Physician will then be notified of the Claims Administrator's decision.

**Obtaining Donor Organs** - The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ:

- evaluation of the organ;
- removal of the organ from the donor; and
- transportation of the organ to the Transplant Center.

**Donor Benefits** - Benefits necessary for obtaining an organ from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post-operative complications if Medically Necessary as determined by the Claims Administrator. Such coverage is available only so long as the recipient's coverage is in effect.

**The Plan does not provide organ transplant benefits for services, supplies or Charges:**

- **that are not furnished through a course of treatment which has been approved by the Claims Administrator or the Plan;**
- **for other than a legally obtained organ;**
- **for travel time and the travel-related expenses of a Provider;**
- **that are related to other than human organ.**

**T. Other Outpatient Services**

1. **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
2. **Dialysis Treatments** - The treatment of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.
3. **Radiation Therapy** - The treatment of disease by X-ray, radium or radioactive isotopes.
4. **Respiratory/Pulmonary Therapy** - Treatment by the introduction of dry or moist gases into the lungs, including, but not limited to, inhalation treatment (pressurized and non-pressurized) for acute airway obstruction or sputum induction for diagnostic purposes.

**U. Outpatient Institutional Services**

The Covered Services listed below are covered when services are performed in an Outpatient setting, except as specified.

Covered Institutional services include, but are not limited to:

- operating, delivery and treatment rooms and equipment;

- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but Charges for the blood are excluded. **Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;**
- anesthesia, anesthesia supplies and services; and
- surgically inserted prosthetics such as pacemakers and artificial joints.

**Pre-Admission Testing** - Outpatient tests and studies required before a scheduled Inpatient Hospital admission or Outpatient surgical service are covered.

**Post-Discharge Testing** - Outpatient tests and studies required as a follow-up to an Inpatient Hospital stay or an Outpatient surgical service are covered.

## V. Outpatient Rehabilitative Services

Rehabilitative therapy services and supplies are used for a person to regain or prevent deterioration of a function that has been lost or impaired due to illness, injury or disabling Condition. Therapy services must be ordered by a Physician or Other Professional Provider to be covered. Covered Services are limited to the therapy services listed below:

1. **Cardiac Rehabilitation Services** - Benefits are provided for cardiac rehabilitation services which are Medically Necessary as the result of a cardiac event. The therapy must be reasonably expected to result in a significant improvement in the level of cardiac functioning.
2. **Chiropractic/Spinal Manipulation Visits** - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part, by a chiropractor. These Covered Services include, but are not limited to, Office Visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. **Braces and molds are not covered under this benefit.**
3. **Hyperbaric Therapy** - The provision of pressurized oxygen for treatment purposes.
4. **Occupational Therapy** - Occupational therapy services are covered if it is expected that the therapy will result in a significant improvement in the level of functioning. All occupational therapy services must be performed by a certified, licensed occupational therapist. **Occupational therapy services are not Covered Services when a patient suffers a temporary loss or reduction of function which is expected to improve on its own with increased normal activities.**
5. **Physical Therapy** - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These Covered Services include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include

devices. Braces and molds are not covered under this benefit. All physical therapy services must be performed by a certified, licensed physical therapist.

- 6. Speech Therapy** - In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessary due to a medical Condition such as:
- a stroke;
  - aphasia;
  - dysphasia; or
  - post-laryngectomy.

#### **W. Private Duty Nursing Services**

The services of a registered nurse, licensed vocational nurse or licensed practical nurse when ordered by a Physician are covered. These services include skilled nursing services received in a patient's home. Your Physician must certify all services initially and continue to certify that you are receiving skilled care and not custodial care, as requested by the Claims Administrator. All Covered Services will be provided according to your Physician's treatment plan and as authorized by the Claims Administrator.

Private duty nursing services include services that the Claims Administrator decides are of such a degree of complexity that the Provider's regular nursing staff cannot perform them. When private duty nursing services must be received in your home, nurse's notes must be sent in with your claim.

**Private duty nursing services do not include care which is primarily nonmedical or custodial in nature such as bathing, exercising or feeding. Also, the Plan does not cover services provided by a nurse who usually lives in your home or is a member of your Immediate Family.**

All private duty nursing services must be certified by your Physician initially and every two weeks thereafter, or more frequently if required by the Claims Administrator, for Medical Necessity.

#### **X. Routine, Preventive and Wellness Services**

##### **1. PPACA and Ohio Preventive Services**

**Health Education Services** - Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.

**Immunizations** - Immunizations are covered.

**Routine Gynecological Services** –

- mammogram services; and
- PAP tests and associated examinations.

**Routine Physical Examinations** - Routine physical examinations are covered.

**Routine Services** - The following services are covered:

- blood glucose screenings, screening for type 2 diabetes limited to asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm/Hg
- bone density screenings, limited to women ages 50 and older
- chlamydia screenings, limited to pregnant and sexually active women age 24 and younger and for older women who are at an increased risk
- cholesterol screenings, limited to:
  - men ages 35 and older for lipid disorders
  - men ages 20 to 35 for lipid disorders if they are at an increased risk for coronary heart disease
  - women ages 20 and older for lipid disorders if they are at an increased risk for coronary heart disease
- colorectal cancer screenings; using fecal occult blood testing, sigmoidoscopy in adults beginning at age 40 and continuing until age 75, and colonoscopy for adults beginning at age 50 and continuing until age 75.
- hepatitis B virus screenings; limited to pregnant women in their first prenatal visit.

**Well Child Care Services** - Coverage for well child care services will be provided for Covered Persons under the age of 21. Coverage for immunizations is also provided for Covered Persons under the age of 21.

Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and developmental assessment. Vision tests, hearing tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests and appropriate immunizations.

**Women's preventive services**, in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence. Coverage is provided for FDA-approved contraceptive methods and counseling.

### **Additional Preventive Services**

If not shown above as a Covered Service, the following services will also be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the

Centers for Disease Control and Prevention with respect to the Covered Person involved;

- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration.

Please refer to the phone number on the back of your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html). Newly added preventive services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guideline, went into effect. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of eligible services.

## **2. Additional Services Beyond PPACA's Requirements**

**Routine Colonoscopy** - for Covered Persons over age 75.

**Routine Testing** - The following tests are covered:

- chest x-ray
- complete blood count
- comprehensive metabolic panel
- electrocardiogram (EKG)
- urinalysis (UA)

## **Y. Skilled Nursing Facility Services**

The benefits available to an Inpatient of a Hospital listed under the Inpatient Hospital Services section are also available to an Inpatient of a Skilled Nursing Facility. These services must be Skilled Care, and your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Plan. All Covered Services will be provided according to your Physician's treatment plan and as authorized by the Plan.

**No benefits are provided:**

- **once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by the Plan; and**
- **for Custodial Care, rest care or care which is only for someone's convenience.**

## **Z. Smoking Cessation Services**

For Covered Persons age 18 and over, benefits are provided for the screening of tobacco use and for smoking cessation programs for those Covered Persons using tobacco.

## AA. Surgical Services

1. **Surgery** - Coverage is provided for Surgery. In addition, coverage is provided for the following specified services:
  - sterilization;
  - therapeutic abortions;
  - removal of bony impacted teeth;
  - maxillary or mandibular frenectomy;
  - diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
  - reconstructive Surgery following a mastectomy, including coverage for reconstructive Surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas;
  - Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by the Claims Administrator, subject to any appeal process. **Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.**

2. **Diagnostic Surgical Procedures** - Coverage is provided for surgical procedures to diagnose your Condition while you are in the Hospital. The diagnostic surgical procedure and Medical Care visits except for the day the surgical procedure was performed are covered.
3. **Multiple Surgical Procedures** - When two or more Surgeries are performed through the same body opening during one operation, you are covered only for the most complex procedure. However, if each Surgery is mutually exclusive of the other, you will be covered for each Surgery. **Incidental Surgery is not covered.**

When two or more surgical procedures are performed through different body openings during one operation, you are covered for the most complex procedure, and the Allowed Amount for the secondary procedures will be half of the Allowed Amount for a single procedure.

If two or more foot Surgeries (podiatric surgical procedures) are performed, you are covered for the most complex procedure, and the Allowed Amount will be half of the Allowed Amount for the next two most complex procedures. For all other procedures, the Allowed Amount will be one-fourth of the full Allowed Amount.

4. **Assistant at Surgery** - Another Physician's help to your surgeon in performing covered Surgery when a Hospital staff member, intern or resident is not available as a Covered Service.
5. **Anesthesia** - Your coverage includes the administration of anesthesia, performed in connection with a Covered Service, by a Physician, Other Professional Provider or certified registered nurse anesthetist who is not the surgeon or the assistant at

Surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty Surgery.

6. **Second Surgical Opinion** - A second surgeon's opinion and related diagnostic services to help determine the need for elective covered Surgery recommended by a surgeon are covered but are not required. The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the Surgery. This benefit is not covered while you are an Inpatient of a Hospital. If the first and second surgical opinions conflict, a third opinion is covered. The Surgery is a Covered Service even if the Physicians' opinions conflict.

## **BB. Urgent Care Services**

Health problems that require immediate attention which are not Emergency Medical Conditions are considered to be Urgent Care needs. Determination as to whether or not Urgent Care Services are Medically Necessary will be made by the Claims Administrator.

Examples of Urgent Care are:

- minor cuts and lacerations;
- minor burns;
- sprains;
- severe earaches or stomachaches;
- minor bone fractures; or
- minor injuries.

## **IX. PROCEDURE FOR FILING A CLAIM FOR MEDICAL BENEFITS**

### **A. How to Apply for Benefits**

#### **1. Notice of Claim; Claim Forms**

A claim must be filed for you to receive benefits. Many Providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from the Provider. If your Provider does not have a claim form, the Claims Administrator will send you one. Call or notify the Claims Administrator, in writing, within 20 days after receiving your first Covered Service, and the Claims Administrator will send you a form or you may print a claim form by going to [www.medicalmutual.com/member](http://www.medicalmutual.com/member).

If you fail to receive a claim form within 15 days after you notify the Claims Administrator, you may send the Claims Administrator your bill or a written statement of the nature and extent of your loss; this must have all the information which the Claims Administrator needs to process your claim.

## **2. Proof of Loss**

Proof of loss is a claim for payment of health care services which has been submitted to the Plan for processing with sufficient documentation to determine whether Covered Services have been provided to you. The Plan must receive a completed claim with the correct information. The Plan may require nurses' or Providers' notes or other medical records before proof of loss is considered sufficient to determine benefit coverage.

The Plan is not legally obligated to reimburse for Covered Services on behalf of the Plan unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. Except in the absence of legal capacity, no proof can be submitted later than one year from the time proof is otherwise required.

If you fail to follow the proper procedures for filing a Claim as described in this SPD, you or your authorized representative, as appropriate, shall be notified of the failure and the proper procedures as soon as possible, but not later than five (5) days following the original receipt of the request. You may be notified orally unless you provide the Plan a written request to be notified in writing. Notification under this section is only required if both (1) the claim communication is received by the person or department customarily responsible for handling benefit matters and (2) the claim communication names a specific claimant, a specific medical Condition and a specific treatment, service or product for which approval is requested.

### **B. How Claims are Paid**

You have a choice when selecting a Provider. This Plan provides coverage for PPO Network Providers, other Contracting Providers and Non-Contracting Providers. However, the type of Provider you choose to utilize can have a large impact on your out-of-pocket expenses. The Claims Administrator pays for benefits on behalf of the Plan for Covered Services through agreements with Contracting Providers based on the Allowed Amount. For Non-Contracting Providers, the Claims Administrator pays for benefits based on the Non-Contracting Amount that is determined payable by Claims Administrator. Please review the following descriptions for additional information.

#### **1. PPO Network and other Contracting Providers**

The Claims Administrator has agreements with Providers both inside and outside the PPO Network, both of which are referred to as Contracting Providers. While the highest level of benefits is provided when you obtain Covered Services from PPO Network Providers, both PPO Network Providers and other Contracting Providers have agreed not to bill for any amount of Covered Charges above the Allowed Amount, except for services and supplies for which the Plan has no financial responsibility due to a benefit maximum. The Allowed Amount is the lesser of the applicable Negotiated Amount or the Covered Charge. Refer to the Schedules of Benefits to determine the amount of Copayments, Deductibles and Coinsurance that apply when utilizing PPO Network Providers versus other Contracting Providers and Non-Contracting Providers.

## **2. Non-Contracting Providers**

If you choose to obtain services from a Non-Contracting Provider, your out-of-pocket expenses will likely be significantly higher than what you would pay by choosing a PPO Network Provider. Copayments, Deductibles and Coinsurance are usually higher when utilizing a Non-Contracting Provider, as shown on the Schedules of Benefits. Also, the Plan calculates its payments to Non-Contracting Providers based upon the Non-Contracting Amount. This means that in addition to your increased out-of-pocket expenses described above, you may also be responsible for Excess Charges, up to the amount of the Provider's Billed Charges. This is sometimes referred to as "balance billing." Excess Charges billed by Non-Contracting Providers DO NOT apply to the Out-of-Pocket Maximum.

If you obtain Covered Emergency Services from a Non-Contracting Provider, the Plan pays for benefits in an amount equal to the greatest of the following:

- a. The Negotiated Amount. If more than one amount is negotiated with Contracting Providers for the Emergency Service, the amount payable is the median of these amounts.
- b. The Non-Contracting Amount.
- c. The amount that would be paid under Medicare for the Emergency Service.

Any charges exceeding the Allowed Amount, Non-Contracting Amount or the amount payable for Emergency Services received from a Non-Contracting Provider described above will not apply toward any Deductible, Out-of-Pocket Maximum or benefit maximum accumulation.

## **3. Your Financial Responsibilities**

You are responsible for:

- Any Copayment, Deductible and Coinsurance amounts specified in the Schedule of Benefits. Copayments are generally required to be paid at the time of service. Some Providers can determine the amount due for your Deductible and Coinsurance from the Claims Administrator and may require payment from you before providing their services.
- Non-Covered Charges
- Billed Charges for all services and supplies after benefit maximums have been reached.
- Excess Charges for services and supplies rendered by Non-PPO Network and Non-Contracting Providers.
- Billed Charges for services that are not Medically Necessary.
- Incidental charges.

For Covered Services, the Claims Administrator will calculate its payment based upon either the Allowed or Non-Contracting Amount.

For Covered Services received from Contracting Providers, the Providers agreed not to bill for any amount of Covered Charges above the Negotiated amount, except for services and supplies for which the Plan has no responsibility due to a benefit maximum.

For Covered Services received from Non-Contracting Providers, the Claims Administrator will calculate the payments based upon the Non-Contracting Amount. You may be responsible for Excess Charges up to the amount of the Provider's Billed Charges. You may also be responsible for the Non-PPO Network Coinsurance for Covered Services received from Contracting Non-PPO Network Providers. The Non-PPO Network Coinsurance continues until your Non-PPO Network Out-of-Pocket Maximum is reached. Any Excess Charges billed by Non-Contracting Providers DO NOT apply to the Non-PPO Network Out-of-Pocket Maximum.

All limits and Coinsurance applied to a specific diagnosed Condition include all services related to that Condition. If a specific service has a maximum, that service will also be accumulated to all other applicable maximums.

Deductibles, Copayments, Coinsurance and amounts paid by other parties do not accumulate towards benefits maximums.

#### **4. Benefit Period Deductible**

Each Benefit Period, you must pay the dollar amount(s) shown in the Schedule of Benefits as the Deductibles, if applicable, before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, the Plan records must show that you have Incurred claims totaling the specified dollar amount, so submit copies of all your bills for Covered Services. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in which the Claims Administrator receives and processes your claims.

Only the amount of the Deductible required per Covered Person will be required for Covered Services that result directly from an accident during the Benefit Period in which the accident occurred if two or more Covered Persons in a Card Holder's family are injured in the same accident, and each of the following conditions are met:

- a. At least two of these Covered Persons receive Covered Services; and
- b. The Covered Services are Incurred within 90 days after the accident; and
- c. The combined Allowed Amount for Covered Services for all Covered Persons involved in the accident is at least equal to one Covered Person's Deductible.

You will not be required to pay two Deductibles if two family members are involved in the same accident and the above criteria is met.

## **5. Coinsurance**

After you meet any applicable Deductible, you may be responsible for Coinsurance amounts as specified in your Schedule of Benefits, subject to any limitations set forth in the Schedule of Benefits. The amount of Coinsurance you have to pay may vary depending upon the status of your Provider.

## **6. Copayments**

For some Covered Services, you may be responsible for paying a Copayment at the time services are rendered. These Copayments are your responsibility, and they are not reimbursed by the Plan. Please refer to your Schedule of Benefits for specific Copayment amounts that may apply and whether a Deductible or Coinsurance will also apply.

## **7. Deductible and Out-of-Pocket Credit**

When the Claims Administrator is replacing other group insurance coverage, credit will be given for the satisfaction or partial satisfaction of Deductible and out-of-pocket amounts incurred and applied during the same or overlapping Benefit Period of the previous carrier's plan during the 90 days preceding the effective date of this coverage.

## **8. Schedule of Benefits**

The Deductible(s) and Coinsurance Limit(s) and Out-of-Pocket Maximums that may apply will renew each Benefit Period. Some of the benefits offered in this SPD have maximums.

The Schedule of Benefits shows your financial responsibility for Covered Services. The Plan covers the remaining liability for Covered Charges after you have paid the amounts indicated in the Schedule of Benefits, subject to benefit maximums and the PPO Provider's Negotiated Amounts.

## **9. Provider Status and Direction of Payment**

The Plan has contracted with a PPO Provider who has agreed to make payment directly to PPO Network and Contracting Providers for Covered Services.

Some of the PPO Provider' contracts with Providers, including Institutional Providers, allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of the PPO Provider and/or the Plan, and the PPO Provider and/or the Plan will retain any payments resulting therefrom; however, the Deductibles, Copayments, Coinsurance and benefit maximums, if applicable, will be calculated based upon the Allowed Amount, as described in this SPD.

The choice of a Providers is yours. After a Provider performs a Covered Service, the Plan will not honor your request to withhold payment. The PPO Provider and Plan do not furnish Covered Services but only pays for Covered Services you receive from Providers. Neither the PPO Provider

nor the plan is liable for any act or omission of any Provider. Neither the PPO Provider nor the plan have any responsibility for a Provider's failure or refusal to give Covered Services to you.

The PPO Provider has and retains the sole right to choose which Providers it will contract with, and on what terms, and to amend and terminate those contracts. The PPO Provider has and retains the sole right to designate Providers as Contracting and/or PPO Network.

You authorize the Plan and PPO Provider to make payments directly to Providers who have performed Covered Services for you. The Plan and PPO Provider reserve the right to make payment directly to you. When this occurs, you must pay the Provider and neither the PPO Provider nor the Plan are legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your Provider.

If the Plan or PPO Provider has incorrectly paid for services or it is later discovered that payment was made for services that are not considered Covered Services, then the Plan and PPO Provider have the right to recover payment on behalf of the Group, and you must repay this amount when requested.

Any reference to Providers as PPO Network, Non-PPO Network, Contracting, Non-Contracting, or in a specific tier is not a statement about their abilities.

#### **10. Prior Approval of Non-PPO Network Benefits**

In some cases, the Claims Administrator may determine that certain Covered Services can only be provided by a Non-PPO Network Provider. If Covered Services provided by a Non-PPO Network Provider are approved in advance by the Claims Administrator, benefits will be provided as if the Covered Services were provided by a PPO Network Provider. However, that Provider may not accept the Allowed Amount as payment in full, and you may have to pay the Excess Charges.

To obtain prior approval of treatment by a Non-PPO Network Provider, your Physician must provide the Claims Administrator with:

- a. the proposed treatment plan for the Covered Services;
- b. the name and location of the proposed Non-PPO Network Provider;
- c. copies of your medical records, including diagnostic reports; and
- d. an explanation of why the Covered Service cannot be provided by a PPO Network Provider.

The Claims Administrator will determine whether the Covered Services can be provided by a PPO Network Provider and that determination will be final and conclusive, subject to any available appeals process. The Claims Administrator may elect to have you examined by a Physician of its choice and will pay for any required physical examinations. You and your Physician will be notified if Covered Services provided by a Non-PPO Network Provider will be covered as if they had been provided by a PPO Network Provider.

If you do not receive written approval in advance of receiving Covered Services, benefits will be provided as described in the Schedule of Benefits for Covered Services received from a Non-PPO Network Provider.

#### **11. Preauthorization Notice for Covered Persons Utilizing Non-Contracting Providers or Residing Outside the State of Ohio**

If you reside outside the state of Ohio, you or your Physician should contact the Claims Administrator before you receive the service to ensure that your procedure/service is Medically Necessary. If your Physician requests a procedure that is determined, by the Claims Administrator, to not be Medically Necessary, you will be responsible for all Billed Charges. If your Physician does not preauthorize the procedure, you should call Customer Service at the telephone number on your identification card for instructions on obtaining preauthorization for Medical Necessity from the Care Management Department of the Claims Administrator.

Preauthorization from the Claims Administrator must be obtained from Inpatient admissions to a Hospital and for certain Outpatient tests, procedures and equipment. If the Hospital or your Provider does not preauthorize the admission or Outpatient service, you must obtain preauthorization by calling the Claims Administrator telephone number on your identification card at least two days prior to receiving an Outpatient service or your admission to the Hospital. In the event preauthorization is not obtained, and services from a Non-Contracting Provider are determined to not be Medically Necessary, you will be responsible for all Billed Charges for those services, whether Inpatient or Outpatient.

In the event of an Emergency Admission, the Hospital, you, a family member or your representative must notify the Claims Administrator within 48 hours or two working days of admission, or as soon as reasonably possible, or you may be responsible for all Billed Charges for that Emergency Admission, if that admission is determined to not be Medically Necessary.

Additional Outpatient tests, procedures and equipment may also require preauthorization. Examples of services that may require preauthorization are:

- a. reconstruction surgeries;
- b. durable medical equipment and devices;
- c. MRI's and PET scans;
- d. therapy;
- e. home health care.

For a complete and current listing, please visit the "Tool" section of MyHealthPlan or contact Customer Service at the phone number shown on your identification card. Be sure to check this listing before services are received, as the information is subject to change.

If your Inpatient stay is for an organ transplant, please review the requirements under the Organ Transplant Services section.

Please refer to the Benefit Determination for Claims section for additional preauthorization requirements.

## **12. Explanation of Benefits**

After the Claims Administrator processes your claim, an Explanation of Benefits (EOB) is provided to you electronically or by mail. It lists Covered Services and non-covered services along with explanations for why services are not covered. It contains important amounts and a telephone number if you have any questions.

## **13. Time of Payment of Claims**

Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. If supporting documentation is required, then payment will be made in accordance with federal law. To have a payment or denial related to a claim reviewed, you must send a written request or call Customer Service at the Claims Administrator within 180 days of the claim determination.

## **14. Foreign Travel**

Benefits include coverage for the treatment of Emergency Medical Conditions rendered worldwide. Your coverage is in effect whether your treatment is received in a foreign country or in the United States. When you receive medical treatment in another country, you may be asked to pay for the service at the time it is rendered. To receive reimbursement for the care provided, make sure to obtain an itemized bill from the Provider at the time of service. The Claims Administrator cannot process a bill unless the Provider lists separately the type and cost of each service you received. All billing submitted for consideration must be translated into the English language and dollar amounts converted at the current rate of exchange.

To receive reimbursement for Hospital and/or medical expenses, the services rendered must be eligible for coverage in accordance with the benefits described in this SPD. If you travel to a foreign country and you receive treatment for an Emergency Medical Condition, the Plan will provide coverage at the PPO Network Provider level.

## **15. Circumstances Beyond the Control of the Plan**

If circumstances arise that are beyond control of the Claims Administrator, the Claims Administrator will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Claims Administrator, include, but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Claims Administrator, disability affecting a significant number of a PPO Network Provider's staff or similar causes, or health care services provided under this SPD are delayed or considered impractical. Under such circumstances, the Claims Administrator and PPO Network Providers will provide the health care services covered by this SPD as far as is practical under the circumstances, and according to their best judgment. However, the Claims Administrator and PPO Network Providers will accept no

liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Claims Administrator.

## **C. Benefit Determination for Medical Claims**

### **1. Urgent Care Claims**

A Claim Involving Urgent Care is a claim for Medical Care or treatment with respect to which the application of the timeframes for making non-Urgent Care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of urgent can be made by an individual acting on behalf of the Plan applying the judgment of a prudent lay person who possesses an average knowledge of medicine; however, any Physician with knowledge of the claimant's medical Condition can determine that a claim involves Urgent Care.

If you file a Claim Involving Urgent Care in accordance with the Claims Administrator's claim procedures and sufficient information is received, the Claims Administrator will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after the Claims Administrator's receipt of the claim.

If you do not follow the Claims Administrator's procedures or the Claims Administrator does not receive sufficient information necessary to make a benefit determination, the Claims Administrator will notify you within 24 hours of receipt of the Claim Involving Urgent Care and explain the applicable procedural deficiencies, or the specific deficiencies related to information necessary to make a benefit determination. You will have 48 hours to correct the procedural deficiencies and/or provide the requested information. Once the Claims Administrator receives the requested information, the Claims Administrator will notify you of the benefit determination, whether adverse or not, as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the information.

The Claims Administrator may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

### **2. Concurrent Care Claims**

If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any reduction or termination by the Claims Administrator of such course of treatment before the end of such period of time or number of treatments shall constitute an adverse benefit determination (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator must notify the claimant of the benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

### **3. Pre-Service Claims**

A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by the Claims Administrator as a condition for payment of a benefit (either in whole or in part).

If you file a Pre-Service Claim in accordance with the Plan's claim procedures and sufficient information is received, the Claims Administrator will notify you of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. The Claims Administrator may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify you of such an extension and the date by which it expects to render a decision.

If an extension is needed because you did not provide the necessary information to process your claim, the Claims Administrator will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

### **4. Post-Service Claims**

A Post-Service Claim is any claim that is not a Pre-Service Claim or a Claim Involving Urgent Care.

If you file a Post-Service Claim in accordance with the Plan's claim procedures and sufficient information is received, the Claims Administrator will notify you of its benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. The Claims Administrator may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify you of such an extension and the date by which it expects to render a decision.

If an extension is needed because you did not provide the necessary information to process your claim, the Claims Administrator will notify you, in writing, within the initial 30 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

## 5. Notice of Claims Denial (Adverse Benefit Determination Notices)

You will receive notice of a benefit determination, orally as allowed, or in writing. All notices of an adverse benefit determination will be made in a culturally and linguistically appropriate manner and will include the following:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount, if applicable;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of the Plan's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Please note: The processes described here are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the claims and appeals processes for this plan are subject to change. The rules and/or procedures set forth in the most current claims and appeals regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth herein.

## X. PROCEDURE FOR APPEALING AN ADVERSE DECISION FOR MEDICAL CLAIMS

### A. Appeals

If you are not satisfied with any of the following:

- a benefit determination;
- a Medical Necessity determination;
- a determination of your eligibility to participate in the Plan or health insurance coverage; or
- a decision to rescind your coverage

then you may file an appeal. To submit an appeal electronically, go to the Claims Administrator's website, [www.MedMutual.com](http://www.MedMutual.com), under Member's section, complete all required fields and submit, or call the Customer Service telephone number on your identification card for more information about how to file an appeal. You may also write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

The request for review must come directly from the patient unless he/she is a minor or has appointed an authorized representative. You can choose another person to represent you during the appeal process, as long as the Claims Administrator has a signed and dated statement from you authorizing the person to act on your behalf. However, in the case of a Claim Involving Urgent Care, a healthcare professional with knowledge of your medical condition may act as your Authorized Representative without a signed and dated statement from you.

## **B. Mandatory Internal Appeal**

The Plan offers you a mandatory internal appeal. You must complete this mandatory internal appeal before any additional action is taken, except when exhaustion is unnecessary as described in the following sections.

Mandatory internal appeals must be filed within 180 days from your receipt of a notice of adverse benefit determination. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described in the Filing an Appeal section above.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this plan. The internal appeal process is a review of your appeal by an appeals specialist, a Physician consultant and/or other licensed health care professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, the Plan will provide the identification of

the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

If, during the appeal, the Plan considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of final adverse benefit determination is issued. You will have an opportunity to respond before our time frame for issuing a notice of adverse benefit determination expires. Additionally, if the Plan decides to issue a final adverse benefit determination based on a new or additional rationale, you will be provided that rationale free of charge before the notice of final adverse benefit determination is issued. You will have an opportunity to respond before our timeframe for issuing a notice of final adverse benefit determination expires.

You will receive continued coverage pending the outcome of the appeals process. For this purpose, the Plan may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

### **1. Appeal of a Claim Involving Urgent Care**

You, your authorized representative or your Provider may request an appeal of a Claim Involving Urgent care. The appeal does not need to be submitted in writing. You, your authorized representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Appeals of Claims Involving Urgent Care typically involve those claims for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations (1) could seriously jeopardize the life or health of a patient, or could affect the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request to appeal. The expedited appeal process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action. When you request an internal appeal for an urgent care claim, at the same time you may also file a request for an expedited external review as described below.

### **2. Pre-Service Claim Appeal**

You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The pre-service claim appeal must be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request and must be requested within 180 days of the date you received notice of an adverse benefit determination.

### **3. Post-Service Claim Appeal**

You or your authorized representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

### **4. Adverse Benefit Determination Notifications**

All notices of a Final adverse benefit determination after an appeal will be culturally and linguistically appropriate and will include the following:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific plan provision(s) on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of services, the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the adverse benefit determination was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- a discussion of the decision;
- a description of applicable appeal procedures; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If your claim is denied at the internal mandatory appeal level, then depending on the type of plan you have and the type of claim, there are two different voluntary review options available. You will be eligible for EITHER the External Review Process OR the Voluntary Internal Review Process. These two processes, and the eligibility requirements, are described below.

### **C. External Review Process**

The Plan has established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within four months from your receipt of the notice of denial from the internal mandatory appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process unless under applicable law you are not required to exhaust the internal appeal process (for example, when your claim is entitled to expedited external review or, if you do not receive a timely internal appeal decision);
3. You are or were covered under the plan at the time the service was requested or, in the case of retrospective review, were covered under the plan when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IRO) accredited by a nationally recognized accrediting organization. You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

The Plan is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical Condition and the external review. The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

#### **1. External Review for Non-Urgent Care Claim Appeals**

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to the Claims Administrator's Member Appeals Unit at the address listed above.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you ten business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you. If the IRO reverses the adverse benefit determination, the Plan will provide coverage or payment for the claim.

#### **2. Expedited External Review for Urgent Care Claim Appeals**

A request for an external review for Urgent or Expedited claims may be requested orally or electronically or in writing and should be addressed to the Claims Administrator's Member Appeals Unit. You may request an external review for Urgent or Expedited claims at the same time you request an expedited internal appeal of your claim.

An expedited review may be requested if your Condition, without immediate medical attention, could result in serious jeopardy to your life or health or your ability to regain maximum function; or you have received a final internal appeal denial concerning an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you. If the IRO reverses the adverse benefit determination, the Plan will provide coverage or payment for the claim.

### **3. Voluntary Internal Review Process**

Unless your Group requires you to use an alternative dispute resolution procedure, if your internal mandatory appeal is denied, and your claim does not qualify for an external review, you have the option of a voluntary internal review by the Claims Administrator. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the internal mandatory appeal.

The voluntary internal review may be requested at the conclusion of the internal mandatory appeal. The request for the voluntary internal review must be received by the Claims Administrator within 60 days from the receipt of the internal mandatory appeal decision. The Claims Administrator will complete its review of the voluntary internal review within 30 days from receipt of the request.

The voluntary internal review provides a full and fair review of the claim. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the internal mandatory appeal.

#### **D. Filing a Complaint**

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, you should have the following information available:

- Name of patient;
- Identification number;
- Claim number(s) (if applicable)
- Date(s) of service.

If your complaint is regarding a claim, the Claims Administrator service representative will review the claim for correctness in processing. If the claim was processed according to the terms of the Plan, the customer service representative will telephone the Participant with the response. If attempts to telephone the Participant are unsuccessful, a letter will be sent explaining how the claim

was processed. If an adjustment to the claim is required, the Participant will receive a check, Explanation of Benefits or letter explaining the revised decision.

Quality Care issues are addressed by the Claims Administrator's Quality Improvement Department or committee. If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

#### **E. Commencement of Legal Action**

No action, at law or in equity, shall be brought against the Plan to recover benefits within 60 days after the Claims Administrator receives written proof in accordance with this Benefit Book that Covered Services have been given to you. No such action may be brought later than three years after expiration of the required claim filing limit as specified in the Proof of Loss section.

### **XI. CLAIMS PROCEDURE FOR PRESCRIPTION CLAIMS**

#### **A. What This Section Covers**

This section covers appeals from adverse benefit determinations related to your prescription benefit coverage. The Plan's appeals are conducted by its Third-Party Pharmacy Benefit Manager, CVS/Caremark. If your situation is urgent as defined below, you may request an urgent review and receive a quicker response to your appeal.

#### **B. When and How Must a Prescription Appeal be Filed?**

If there is an adverse benefit determination regarding prescription coverage made against a Covered Person, that person will receive a letter from CVS/Caremark. An appeal of this determination must be received within 180 days of the date of this letter. You or your authorized representative (who may be your doctor) may submit an appeal of this denial in writing along with any documentation that will support your appeal. That documentation should include any information that you or your doctor believe supports your claim. This information could include a letter from your doctor describing why the requested medication is necessary, clinical notes, test results, or any other supporting documentation. Please mail or fax your appeal to:

Prescription Claim Appeals  
MC 109 – CVS/Caremark  
P.O. Box 52084  
Phoenix, AZ 85072  
Fax: 866-443-1172

Your appeal should include the following information:

- Name of the person for whom the appeal is being filed;
- CVS Caremark Identification Number;
- Date of Birth;
- Written statement of the issue(s) being appealed;

- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the claim.

### **C. Who May File an Appeal?**

You or someone you name to act for you (your authorized representative) may file an appeal. You may name your doctor, a relative, friend, advocate, or anyone else as your appointed representative. When submitting your appeal, please provide a letter appointing that person as your representative or provide other similar proof giving that person legal permission to act on your behalf. This letter will need to be submitted with your appeal.

### **D. First Level of Appeal**

If you appeal, the Third-Party Pharmacy Benefit Manager will review its decision and provide you with a written determination within fifteen business days. If the payment, coverage or service requested continues to be denied, or you do not receive a timely decision, you may request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Please refer to the benefit booklet prepared by the Third-Party Pharmacy Benefit Manager if you need assistance understanding your rights.

### **E. Urgent Review**

If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis after your appeal is received. Generally, an urgent situation is defined by law as one in which your health is in serious jeopardy or, in the opinion of your doctor, you will experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you, or your doctor, believe your situation is urgent as defined by law, you or your doctor may request an expedited appeal by calling Customer Care toll-free at the number on your prescription benefit identification card or by faxing your appeal to 866-443-1172. Urgent requests must be clearly identified as “urgent” when sent. If your first level of appeal is expedited, you will receive a response within 72 hours. In certain situations, you may also be able to request a simultaneous external review of your claim.

### **F. Second Level of Appeal**

You or your authorized representative may request an external appeal of a final adverse benefit determination. This second level of appeal will be conducted by an independent review organization (IRO).

#### **1. Request for External Review**

Requests for external review may be made within four months of the adverse benefit determination. Requests for external review may be made by you or your authorized representative by mailing or faxing your request to:

CVS Caremark  
External Review Appeals Department  
MC109  
P.O. Box 52084  
Phoenix, AZ 85072-2084  
Fax: 1-866-443-1172

Your request for external review must include the following:

- Member's Name
- Contact Information Including Mailing Address
- Daytime Phone Number
- Member ID Number
- Copy of the Coverage Denial

## **2. Determination of Whether Claim is Eligible for External Review**

When an external review is received by the IRO, the Third-Party Pharmacy Benefit Manager will perform an initial review to determine if:

- The request is timely;
- The Covered Person requesting the appeal was eligible for benefits at the time service was requested and/or provided;
- The claim is related to a failure to satisfy Plan eligibility requirements;
- The internal appeal process is exhausted unless expedited; and
- The Covered Person has provided all necessary information.

The Third-Party Pharmacy Benefit Manager will notify the Covered Person within six business days whether the request is complete and eligible for review. If the claim is ineligible for review, the Covered Person will be notified of the denial. If the request is incomplete, more information will be requested. A subsequent determination will be made within six business days as to whether the request is complete, or if further information is needed.

## **3. IRO Review**

Upon receipt of a complete and eligible request or external review, the Third-Party Pharmacy Benefit Manager will submit the request and required documentation to the contracted IRO. The IRO will notify the Covered Person of the request and the opportunity to submit more information. The Covered Person has ten days to submit such information. The IRO will then conduct an independent review. The IRO is not bound by the decision made in the first level of appeal. Within 45 business days, the IRO reviews all documentation and will notify the Covered Person or the Plan of its decision.

If the IRO reverses a prior denial on external review, the decision is binding on the Plan and the requested benefit must be provided. If the IRO upholds the denial of the Covered Person's claims, the Covered Person may pursue civil action under Section 502(a) of ERISA.

**G. Providing Additional Information About Your Claim**

You may supply any additional information when you submit your claim. You may also wish to present testimony on your behalf.

**H. Requesting Copies of Information Relevant to Your Claim**

You may request copies (free of charge) by calling the toll-free Customer Care number on your prescription benefit identification card.

**XII. CLAIMS PROCEDURE FOR DISABILITY AND WEEKLY SICKNESS AND ACCIDENT BENEFIT CLAIMS**

**A. How Do I Submit A Claim For Disability Weekly Sickness and Accident Benefits?**

To obtain benefits due to disability for both extended coverage and Weekly Sickness and Accident Benefits, you must provide written notice to the Administrative Manager within thirty (30) days after the Accident or Illness causing your Disability occurs. If written notice cannot be given within that time, it must be given as soon as reasonably possible. The written notice must contain enough information to identify who is making the claim.

When the Administrative Manager receives written notice of your claim, the Administrative Manager will send you an approved claim form, which you must complete and submit. Upon receipt of the completed form, the Administrative Manager may, in his/her sole discretion, require you to be examined or have your claim reviewed by a physician or clinic chosen by the Administrative Manager on behalf of the Trustees or require you to submit additional evidence to support your claim for disability and/or weekly sickness and accident benefits.

**B. When Will I Be Notified Of A Decision On My Claim For Extended Coverage and Weekly Sickness and Accident Benefits?**

In the event your claim for extended coverage due to Disability and/or Weekly Sickness and Accident benefits is denied, you will be notified in writing by the Administrative Manager the reasons why your claim was denied. Notification of an adverse decision shall occur within forty-five (45) days of the receipt of your approved claim form by the Administrative Manager. If the Administrative Manager determines that more time is needed to process the claim due to matters beyond his/her control, the Administrative Manager will notify you of a thirty (30) day extension. If a second extension is necessary due to matters beyond his/her control, the Administrative Manager will notify you of a final thirty (30) day extension. No further extensions shall occur. Any notice of an extension shall include the standards on which an entitlement to benefits due to Disability is based, the unresolved issues preventing a decision and any additional information that is needed to resolve the claim.

**C. What Information Will Be Contained In My Notice On My Claim For Disability?**

All claims and appeals for extended coverage and Weekly Sickness and Accident benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based on the likelihood that the individual will support a denial of benefits.

In the event of non-approval in whole or in part of your claim, notice to you shall provide you all of the following information in the written decision:

- (1) the specific reasons for rejecting the application; and
- (2) the specific provisions of the Plan or rules and regulations on which the determination is based; and
- (3) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and
- (4) an explanation of the Appeals Procedure; and
- (5) a statement regarding your right to bring a civil action under ERISA §502(a) following an adverse benefit determination on appeal; and
- (6) the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the decision or, alternatively a statement that such rules, guidelines, protocols, standards or similar criteria of the plan do not exist; and
- (7) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to your claim for benefits

In addition, in the event the determination disagrees with the views of (1) a health care professional treating you; (2) vocational professionals who have evaluated you; (3) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with your claim; or (4) a disability determination regarding you made by the Social Security Administration; then the decision to deny shall set forth an explanation of the basis for disagreeing with those views or opinions. If the decision to deny was based on a medical necessity, experimental treatment or similar exclusion or limit, the decision will set forth either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

The decision shall be final and binding upon you unless that decision is appealed as hereinafter set forth below.

**D. How Do I Appeal A Decision To Deny My Claim To Board of Trustees?**

In the event your claim for benefits is denied, you may, by written notice received by the Administrative Manager within one hundred and eighty (180) days of your receipt of the notice denying your claim for benefits, appeal the decision. The written notice should state your name, address and the reasons why you are appealing from the decision of the Administrative Manager, giving the date of the decision you are appealing.

The review of your appeal will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject of the appeal nor a subordinate of such individual. If the appeal of a decision based in whole or in part on medical judgment, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. The reviewer will also identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with the initial adverse benefit determination, without regard to whether the advice was relied upon by the initial determination.

Prior to making a decision to deny an appeal, you will be provided, free of charge, with any additional evidence considered, relied upon, or generated by the Plan, the disability insurer, or other person making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date. If the determination is based on new or additional rationale, the plan administrator shall provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date.

The Trustees shall consider your appeal no later than its next regularly scheduled meeting, which immediately follows the receipt of the notice of appeal unless such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, then the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal. If such extension is required, you will be provided with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made prior to commencement of the extension.

After consideration of the appeal as above, the Board of Trustees shall advise you of its decision in writing within five (5) days after the benefit determination is made. If the determination is adverse to you, the written decision shall state all of the following information:

- (1) the specific reasons for rejecting the appeal; and
- (2) the specific provisions of the Plan or on which the determination is based; and
- (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- (4) a statement of your right to bring an action under Section 502(a) of ERISA; and
- (5) the applicable contractual limitations period that applies to your right to bring such an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim; and
- (6) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination, or, alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- (7) a discussion of the decision including an explanation for disagreeing with or not following any of the following:
  - a. the views of health care professionals treating the claimant; or
  - b. the views of vocational professionals who evaluated the claimant; or
  - c. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the benefit determination; or
  - d. a disability determination made by the Social Security Administration.

If the adverse benefit determination is based on medical necessity, experimental treatment or a similar exclusion or limit, you will be provided either with an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

All notices to you shall be made in a culturally and linguistically appropriate manner. The Plan will provide oral language services such as a telephone customer assistance hotline that include answering questions in any “applicable non-English language” and providing assistance with filing claims and appeals in “any applicable non-English language.” In addition, the Plan will provide, upon request, a notice in any “applicable non-English language” and will include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. “Applicable non-English languages” include, with respect to an address in any United States county to which a notice

is sent, a non-English language in which ten percent or more of the population residing in the county is literate only in that language.

The Trustees shall have full authority to interpret the provisions of this Plan and it is within the sole and absolute discretion of the Trustees to determine if you are entitled to receive a benefit and the amount of the benefit. The decision shall be final and binding upon you.

If, after following the applicable review processes outlined above, you are not satisfied with the result, then you may file a legal action against the Plan or the Trustees within two (2) years of receiving the final review notice under these procedures. No legal action may be commenced or maintained more than two (2) years after you receive notice of the Trustees' decision on review under the Plan's appeal procedure. Any such legal action must be filed in the United States District Court for the Northern District of Ohio, Eastern Division.

### **XIII. ASSIGNMENT OF BENEFITS**

Benefits under this Plan may be assigned by you or your Eligible Dependent(s) to a provider of services only. Assigned benefits shall be paid to the Assignee regardless of your intervening death. No claim payment may be made to your creditors or any other person or entity except as provided specifically in the Plan. No right or interest of you (or your beneficiary) to benefits provided under the Health and Welfare Plan (other than to a provider of services only) shall be assignable, pledged, alienated, transferred or otherwise encumbered.

### **XIV. COORDINATION OF BENEFITS**

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the Primary plan is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

#### **A. Definitions**

1. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
  - a. **Plan** includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other

forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

- b. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
2. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.
3. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

4. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

- a. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private Hospital room expenses.
- b. If a person is covered by 2 or more **Plans** that compute their benefit

payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

- c. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
- d. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the Provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
- e. The amount of any benefit reduction by the **Primary plan** because a Covered Person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and preferred provider arrangements.

- 5. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.
- 6. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## **B. Order of Benefit Determination Rules**

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- 1. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

- a. Except as provided in Paragraph “b” below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
  - b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
2. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
  3. Each **Plan** determines its order of benefits using the first of the following rules that apply:
    - a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
    - b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
      1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
        - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
        - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
        - However, if one parent's plan has some other coordination rule (for example, a “gender rule” which says the father's plan is always primary), we will follow the rules of that plan.
      2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
        - a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care

coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

- b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
  - c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
  - d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The **Plan** covering the **Custodial parent**;
    - The **Plan** covering the spouse of the **Custodial parent**;
    - The **Plan** covering the **non-custodial parent**; and then
    - The **Plan** covering the spouse of the **non-custodial parent**.
3. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.
- c. Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
  - d. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule,

and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

- e. Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- f. If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

#### **C. Effect on the Benefits of This Plan**

- 1. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
- 2. If a Covered Person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

#### **D. Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Insulators Local 84 Health Care Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Insulators Local 84 Health Care Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Insulators Local 84 Health Care Plan any facts it needs to apply those rules and determine benefits payable.

### **E. Facility of Payment**

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, The Insulators Local 84 Health Care Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Insulators Local 84 Health Care Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

### **F. Right of Recovery**

If the amount of the payments made by the Insulators Local 84 Health Care Plan is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

### **G. Coordination Disputes**

If you believe that we have not paid a claim properly, you should attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card.

## **XV. SUBROGATION, RESTITUTION, AND REIMBURSEMENT**

### **A. Definitions**

- (1) “Constructive Trust” shall mean a trust in which any amount, compensation and/or money the Participant and/or Eligible Dependent and/or the Participant's or Eligible Dependent's heirs, estate or assigns (hereinafter collectively referred to as “Participant”) recovers shall be deemed to be held for the Participant’s exclusive benefit and not commingled with other funds. Any such Constructive Trust shall be subject to an equitable first lien by the Plan and any other equitable remedies available to the Plan under ERISA §502(a)(3) for the purpose of preserving the Plan’s right to restitution for benefits paid by the Plan on the Participant’s behalf.
- (2) “Reimbursement” shall mean repayment to the Plan for, any benefit, that the Plan paid toward care and/or treatment for an injury, disease or illness.
- (3) “Restitution” shall mean the return or restoration to the Plan of, any benefit, , the Plan paid toward care and/or treatment for a condition
- (4) “Subrogation” shall mean the Plan’s right to recover any benefit payment:
  - (i) because of injury, disease or illness to the Participant caused by either the Participant or a third party’s conduct; and

- (ii) the Participant later recovers from a third party's insurer or Participant's own insurer.
- (5) "Third party" shall mean another person, entity or organization.

**B. Subrogation, Restitution and Reimbursement Rights**

- (1) To the extent of any payment made under the Plan, the Plan shall be subrogated to the Participant's rights of recovery, which rights arise from any claim or cause of action which may occur because of the Participant's or a third party's conduct. This right of subrogation, restitution and reimbursement extends to any recovery received by the Participant, regardless of how it is characterized, such as for pain and suffering, regardless of who makes the payment, for any type of third-party injury. This also includes, but is not limited to:
  - (i) Payments made directly by a third party, or any insurance company on behalf of a third party or any other payments on behalf of a third party;
  - (ii) Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on the Participant's or other person's behalf;
  - (iii) Any other payments from any source designed or intended to compensate the Participant for injuries sustained as the result of negligence or alleged negligence of a third party.
  - (iv) Any worker's compensation award or settlement;
  - (v) Any recovery made pursuant to no-fault insurance;
  - (vi) Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

The Plan has a first priority lien on any recovery. The Participant and the Participant's attorney are deemed to hold any recovery in Constructive Trust on behalf of the Plan. The Plan is entitled to repayment in full, without reduction for attorney's fees and costs, and regardless of whether the Participant is made whole or fully compensated. The Plan will not pay future claims to the extent of any recovery the Participant received in the past in connection with an accident, unless the Plan's claim for subrogation, restitution or reimbursement has been satisfied.

- (2) The Plan shall automatically have a first lien upon any recovery that the Participant receives, or may be entitled to receive, from a third party. The Lien shall be in the amount of the benefits paid under this Plan for the treatment of any illness, disease, injury or condition for which the Responsible Third Party may be liable to the Participant.

- (3) The Plan shall be entitled to equitable relief, including without limitation the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and to obtain (or to preclude the transfer or dissipation of) any recovery. The Plan shall be entitled to enforce its lien even if the recovery is less than the actual loss suffered by the Participant.
- (4) The Plan shall have a specific and first right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any recovery that the Participant may receive from a Responsible Third Party.
- (5) The Participant and the Participant's representatives are required to provide all assistance and cooperation requested by the Plan so that the Plan can exercise its subrogation, restitution and reimbursement rights. If the Participant or the Participant's representative fail to cooperate with the Plan, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefit of whatever kind including, but not limited to, recovery from any full or partial recovery of revenue/money including, but not limited to, full or partial recovery for pain and suffering, loss of wages and punitive damages until the Participant cooperates to the satisfaction of the Plan. In addition, if the Participant fails to cooperate and/or pay the Plan the full amount owed, the Plan shall have the right to withhold the Participant's payment(s) for future or different claims on behalf of the Participant or Participant's dependents until the amount owed in the subrogation, restitution or reimbursement claim, in the estimation of the Plan, has been obtained through the withholding of the claims.
- (6) The Participant and Participant's attorney are required to sign the Plan's subrogation, restitution and reimbursement agreement prior to the Plan's payment of any benefits on the Participant's behalf for any injury, disease or illness resulting from the actual or alleged negligent conduct of a third party. This Plan's subrogation, restitution and reimbursement agreement may be obtained from the fund office or the administrative manager and may include terms and conditions beyond the scope of provisions listed in the Summary Plan Description. The Plan's subrogation, restitution and reimbursement agreement the Participant signs will obligate the Participant, among other things, to reimburse the Plan for any benefits paid by the Plan from any monies or other property recovered if the Participant recovers any monies or other property from a third party as the result of a judgment, settlement or other recovery against or with a third party or if the Participant recovers under the Participant's own insurance coverage, including uninsured or underinsured coverage. If the Participant is represented by an attorney, the Participant's attorney is also required to sign the subrogation, restitution and reimbursement agreement. If the Participant does not have an attorney at the time of signing the subrogation, restitution and reimbursement agreement but subsequently becomes represented by an attorney, the Participant is required to have the Participant's attorney sign a subrogation, restitution and reimbursement agreement at the time the Participant's attorney begins representation

- (7) If the Participant and Participant's attorney do not sign a subrogation, restitution and reimbursement agreement, and the Plan Administrator later learns that benefits were paid to the Participant or on the Participant's behalf because of medical treatment which was rendered due to the negligent (actual or alleged) conduct of a third party or the Participant, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefits of whatever kind until the Participant signs a subrogation, restitution and reimbursement agreement. In addition, the Participant and Participant's attorney are obligated to avoid doing anything that would prejudice the Plan's right of subrogation, restitution and reimbursement.
- (8) If litigation is commenced, the Plan may cause to be recorded a Notice of Payment of Benefits, and such notice will constitute a first lien on any judgment recovered less a pro rata of court costs. Further, if litigation is commenced, the Participant and the Participant's attorney are required to deliver to the Plan a copy of the complaint filed in court, the name of the insurance company for the defendant(s) and any other instruments, documents or information for which the Plan requests to insure the Plan's subrogation, restitution and reimbursement rights. The Plan shall have the right to intervene in any litigation involving the Participant to protect its subrogation, restitution and reimbursement rights. Any action taken by the Plan to protect its subrogation, restitution and reimbursement rights shall be without any charge or cost to the Participant. However, the Plan shall not be liable to pay the Participant's attorney fees or costs or the Participant's attorney or his/her costs.
- (9) The Participant is required to segregate any recovery received by the Participant (up to the amount of the Plan's first lien) in a separate account, and the Participant must preserve such recovery so that the Plan may enforce its lien and any disputes as to entitlement may be resolved.
- (10) The Participant may not assign any right, claim or cause of action against a Responsible Third Party to recover for any illness, disease, injury or condition on account of which benefits were paid by the Plan.
- (11) The Plan's rights of reimbursement, restitution and subrogation shall not be affected, reduced or eliminated by the make whole doctrine, comparative or contributory fault, or the common fund doctrine, or payment of the Participant's attorney fees or court costs.

## **XVI. QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

This Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (hereinafter "QMCSO"), as required by ERISA Section 609.

This Plan, in accordance with law, must recognize a Qualified Medical Child Support Order. A "medical child support order" is a judgment, decree, or order (including approval of a settlement agreement) entered by a court or administrative agency of competent jurisdiction that:

- (1) Provides for child support with respect to a Participant's child under a group health plan or provides for health benefit coverage to a Participant's child; and
- (2) Is made pursuant to a state domestic relations law.

A "medical child support order" is a "Qualified Medical Child Support Order" (QMCSO) if it creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or beneficiary is eligible under a group health plan, specifies required information, and does not alter the amount or form of plan benefits. An "alternate recipient" means any Child of a Participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such Participant.

Thus, if a Qualified Medical Child Support Order provides health benefit coverage under the Plan to an alternate recipient, the Trustees are required to comply with the QMCSO. Participants may obtain a copy of the QMCSO procedures from the Plan Administrator without charge.

## **XVII. FAMILY AND MEDICAL LEAVE**

This Plan will provide benefits in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 (hereinafter "FMLA"). Pursuant to the FMLA, eligibility for benefits shall be extended to active Participants and their dependents if the Participant has been granted unpaid leave by his/her Employer pursuant to the FMLA and meets all eligibility requirements of FMLA.

In order to prevent a loss of eligibility to the Participant, the Participant and/or the Employer granting the FMLA leave must comply with the following requirements:

- (1) Notify the Fund Office at least fourteen (14) days before the onset of FMLA leave, except in an emergency, and then no later than seven (7) days after FMLA leave begins;
- (2) Obtain and submit to the Fund Office a certificate of the Participant's eligibility for FMLA leave; and
- (3) Notify the Fund Office of the beginning date and ending date of the FMLA leave.

The Employer will be required to continue to submit payment for the cost of the Participant's (and their Eligible Dependent's) coverage during the FMLA leave. In addition, the Employer granting the FMLA leave must notify the Administration Office of the date a Participant advises the Employer that he/she does not intend to return to work. If a Participant on FMLA leave advises the Employer that he/she does not intend to return to work, then the obligation of the Employer to submit payment for the cost of the Participant's coverage will immediately cease.

## **XVIII. PRIVACY POLICY UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

### **A. Definition of Protected Health Information.**

The Board of Trustees sponsors the Plan and is the Plan's designated Plan Sponsor. The Plan's administrative staff may have access to the individually identifiable health information of Plan participants required for the Plan's administrative functions. When this health information is provided by the Plan to the Plan Sponsor, Business Associates, subcontractors, and other service providers to the Plan, such information is Protected Health Information ("PHI").

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA, as amended.

On January 25, 2013, HIPAA's Privacy, Security, Enforcement and Breach Notification rules were modified by the Health Information Technology for Economic and the Clinical Health Act of 2009 ("HITECH Act") and the Genetic Information Nondiscrimination Act of 2008 ("GINA") (collectively referred to as the "HIPAA Omnibus Rules"). These modifications were effective on or after March 26, 2013.

The following definition of PHI shall apply for purposes of compliance with all HIPAA Omnibus Rules and HIPAA regulations:

1. PHI is information that is created or received by the Plan and relates to the past, present, or future:
  - a. physical or mental health condition of a Covered Person;
  - b. provision of health care to a Covered Person;
  - c. payment for the provision of health care to a Covered Person;
  - d. identification of the Covered Person; or
  - e. belief that the information can be used to identify the Covered Person.
2. PHI may be created, received, maintained, or transmitted to or from the Plan according to the following methods:

- a. by electronic media;
  - b. in electronic media; or
  - c. in any other written or oral form or medium.
3. PHI excludes individually identifiable health information contained in:
- a. education records covered by the Family Educational Rights and Privacy Act, as amended;
  - b. medical records described at 20 U.S.C. 1232g(a)(4)(B)(iv);
  - c. employment records held by a covered entity in its role as Employer; and
  - d. records of a Covered Person who has been deceased for more than 50 years.

**B. Permitted Uses of Protected Health Information.**

The Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. For this purpose, payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These payment activities include, but are not limited to, the following:

1. determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, plan maximums, and co-payments as determined for an individual's claim);
2. coordination of benefits;
3. adjudication of health benefit claims (including appeals and other payment disputes);
4. subrogation of health benefit claims;
5. establishing employee contributions;
6. calculation of amounts due to risk adjustments or other factors;
7. billing, collection activities, and related health care data processing;
8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and

responding to participants' (and their authorized representatives') inquiries about payments;

9. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary, in the future;
10. medical necessity reviews, or reviews of appropriateness of care or justification of charges;
11. utilization review, including pre-certification, preauthorization, concurrent review, and retrospective review; and
12. reimbursements to the Plan.

For purposes of determining uses or disclosures of PHI relating to health care operations, the term "health care operations" includes, but is not limited to, the following activities:

1. quality assessment;
2. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives; and related functions;
3. rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;
4. underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
5. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
7. the Plan's management and general administrative activities, including, but not limited to:
  - a. management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;

- b. participant and provider service, including the provision of data analysis;
  - c. resolution of internal grievances; and
  - d. filing of governmental forms, including Internal Revenue Service Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code.
8. For “research” purposes, defined by current HIPAA Omnibus Rules and regulations as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge. An Employer may use or disclose PHI which has been appropriately de-identified according to HIPAA regulations for research purposes.

The Plan will use and disclose PHI for administrative purposes, only as required by law and permitted by authorization of Covered Persons or their beneficiaries. The Plan will disclose PHI to other related benefit plans which may provide retirement and/or disability benefits to a Covered Person or beneficiary, but only upon written authorization from such Covered Person and the execution of a Business Associate Agreement by such benefit plan. Such uses and disclosures will be made for purposes solely related to administration of the Plan.

**C. Permitted Uses and Disclosure of Summary Health Information.**

The Plan (or a health insurance issuer) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of:

1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. modifying, amending, interpreting, or terminating the Plan.

For this purpose, the term “Summary Health Information” means information that:

1. summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and
2. has been de-identified in accordance with the HIPAA Omnibus Rules.

**D. Activities That Require Permission for Use or Disclosure of Protected Health Information.**

In accordance with rules promulgated by the HIPAA Omnibus Rules, the Plan must have the express written permission/authorization of any Covered Persons (or their beneficiaries) to use or disclose PHI to engage in the following activities:

1. the use or transmission of psychotherapy notes related to the treatment of any Covered Person;
2. the use of PHI when the Plan receives financial remuneration from a third party for communications regarding treatment and health care, when that third party is marketing its product or service to the Plan or Eligible Employees;
3. the sale of PHI for any reason; or
4. activities which are not specified or described in the Plan.

Covered Persons who wish to provide written permission/authorization to the Plan to use or disclose PHI for such activities may obtain permission/authorization forms from the Fund Office. In addition, Covered Persons may revoke such express written permission/authorization at any time by contacting the Fund Office and executing an updated form.

**E. Use of Genetic Protected Health Information Prohibited.**

In accordance with regulations under GINA, the Plan is prohibited from using any Covered Person's "genetic information" for any underwriting purposes. Genetic information includes manifestations of diseases or disorders that have appeared in a Covered Person's family history but have not appeared in the Covered Person's health record.

**F. Disclosure Restrictions on Protected Health Information for Health Care Expenses Paid in Full by Covered Persons.**

In accordance with regulations under HITECH, a Covered Person has the right to restrict disclosures of his or her PHI to the Plan when the Covered Person pays out of pocket, in full, for any health care item or service.

**G. Opting Out of Fundraising Activities Involving Protected Health Information.**

All Covered Persons have the right to opt out of fundraising activities sponsored by, or engaged in, by the Plan Sponsor which involve the use of PHI. However, the Plan Sponsor may include the use of demographic information, health insurance status, or dates of health care for Covered Persons in order to raise money for a non-profit organization or charity.

The Plan Sponsor shall include a reminder of a Covered Person's rights and methods to opt out fundraising activities whenever the Plan Sponsor sends fundraising communications.

**H. Protected Health Information Breaches Required to be Disclosed under HIPAA Regulations.**

The Board of Trustees shall report to the Plan any breach of PHI of which it becomes aware. All Covered Persons will receive a detailed written explanation whenever an event occurs that results in a breach of unsecured PHI. For this purpose, the term "breach" means the acquisition, access, use, or disclosure of PHI in a manner which is prohibited by HIPAA regulations and which compromises the security or privacy of PHI. The impermissible use or disclosure of PHI is presumed to be a breach unless the Plan Sponsor or Business Associate specifically demonstrates that there is a low probability that PHI has been comprised.

**I. Covered Person's Right to Receive Protected Health Information from the Plan Sponsor.**

All Covered Persons have the right to obtain a copy of their PHI from the Plan Sponsor in electronic or hardcopy format. To obtain this information, a Covered Person must make a written request to the Fund Office.

**J. Conditions of Disclosure for Plan Administration Purposes.**

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified in accordance with the HIPAA Omnibus Rules) disclosed to it by the Plan (or a health insurance issuer), the Plan Sponsor shall:

1. not use or further disclose PHI, other than as permitted or required by plan documents, privacy notices, Business Associate Agreements, or as required by current laws and regulations;
2. ensure that any Business Associates, providers, agents or plan representatives, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information by executing written Business Associate Agreements;
3. not use or disclose PHI for employment-related actions and decisions unless authorized by Covered Persons or their beneficiaries;
4. not use or disclose PHI in connection with any other benefit or employee benefit plan unless authorized by the Covered Persons or as otherwise specifically provided herein;

5. report to the Plan and Covered Persons any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Omnibus Rules of which it becomes aware;
6. make PHI available to a Covered Person in accordance with the current access requirements of the HIPAA Omnibus Rules;
7. make PHI available to a Covered Persons to permit the individual affected by such information to make amendments to such PHI in accordance with the HIPAA Omnibus Rule;
8. make available the PHI required to provide an accounting of PHI disclosures in accordance with the HIPAA Omnibus Rules;
9. make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the United States Department of Health and Human Services (“HHS”) for the purposes of determining compliance by the Plan with the HIPAA Omnibus Rules and regulations;
10. if feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which permissible disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
11. implement administrative, physical, and technical safeguards that reasonably de-identifies and appropriately protects the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan; and provide for adequate separation, which is supported by reasonable and appropriate security measures between the Plan and the Board of Trustees, as set forth below.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified accordance with the HIPAA Omnibus Rules) on behalf of the covered entity, the Board of Trustees shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. Further, the Plan Sponsor shall ensure that any agents, Business Associates (including subcontractors) to whom it provides such electronic PHI agree to implement similar safeguards, using reasonable and appropriate security measures to de-identify or otherwise protect the information. For these purposes, “electronic PHI” means any PHI that is transmitted by, or maintained in, electronic media.

## **K. Business Associate Agreements.**

Any contract between the Plan and a Business Associate must be set forth in a Business Associate Agreement that complies with the requirements of the HIPAA Omnibus Rules. For this purpose, the term “Business Associate” means a person or entity that performs certain functions or activities on behalf of, or that provides certain services to, the Plan involving access by the Business Associate to PHI. The term “Business Associate” also includes a subcontractor that creates, receives, maintains, or transmits PHI on behalf of another Business Associate.

Functions and activities that are performed by a Business Associate include the following:

For purposes of compliance with the HIPAA Omnibus Rules, the term “Business Associate Agreement” means a contract between the Plan and a Business Associate that satisfies the requirements of the HIPAA Omnibus Rules, including the following:

1. establishes the permitted and required uses of PHI by the Business Associate;
2. provides that the Business Associate will not use or further disclose the PHI other than as permitted or required by the Business Associate Agreement or as required by law;
3. requires the Business Associate to use appropriate safeguards to prevent a use or disclosure of PHI other than as provided for by the Business Associate Agreement;
4. requires the Business Associate to make available to HHS the Business Associate’s internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the Plan for purposes of allowing HHS to assess the Plan’s compliance with the HIPAA’s privacy requirements;
5. at termination of the contract, if feasible, requires the Business Associate to return or destroy all PHI received from, or created or received by the Business Associate on behalf of, the Plan;
6. requires the Business Associate to ensure that any subcontractors it may engage on its behalf that will have access to PHI agree to the same restrictions and conditions that apply to the Business Associate with respect to such information;
7. authorizes termination of the contract by the Plan if the Business Associate violates a material term of the contract; and
8. requires the Business Associate to report to the Plan any use or disclosure of the information not provided for by its Business Associate Agreement, including incidents that constitute breaches of unsecured PHI.

Contracts between Business Associates and Business Associates that are subcontractors are subject to the same requirements under the HIPAA Omnibus Rules as contracts between the Plan and Business Associates.

**L. Persons Entitled to Access to Protected Health Information.**

In accordance with the HIPAA Omnibus Rules, only the following employees or classes of employees may be given access to PHI:

1. the Plan's Administrative Manager;
2. staff designated by the Plan's Administrative Manager, Investment Manager, or other approved Business Associates; and
3. members of the Board of Trustees and the Plan's legal counsel.

These persons may have access to and use and disclose PHI only for plan administration functions that are performed on behalf of the Plan. If these persons do not comply with the Plan's limitation on the use of PHI, the Board of Trustees shall provide for the resolution of issues of noncompliance, including notifying Covered Persons in writing and imposing disciplinary sanctions.

**M. Adequate Separation between Plan and Plan Sponsor.**

The Plan Sponsor will allow third party service providers access to PHI, subject to the Business Associate Agreement restrictions under Section K. above. No other persons shall have access to PHI. These specified individuals or entities shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these service providers fail to comply with the Business Associate Agreement restrictions under Section K. above, such service provider shall be subject to termination pursuant to the Business Associate Agreement in place.

The Plan Sponsor shall ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

**N. Certification of Plan Sponsor.**

The Plan (or a health insurance issuer) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate applicable provisions of HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth in J. above.

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (a) that it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (b) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining

premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated in this Summary by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor will, in accordance with the Security Regulations, take the following measures:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the “ePHI” that it creates, receives, maintains or transmits on behalf of the Plan.
2. Ensure that “adequate separation” is supported by reasonable and appropriate security measures. “Adequate separation” means that the Plan Sponsor will use ePHI only for activities related to the Plan’s administration and not for employment-related actions or for any purpose unrelated to the Plan’s administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan’s security or privacy policies and procedures or the Plan’s provisions regarding such policies and procedures is subject to the Plan’s disciplinary procedure.
3. Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.
4. Report to the Plan any security incident of which it becomes aware.

#### **O. Privacy Officer**

The Plan’s Privacy Officer is currently BeneSys, Inc., 33 Fitch Boulevard, Austintown, OH 44515, phone number (330) 779-8884.

### **XIX. MISCELLANEOUS PROVISIONS**

#### **A. Change of Plan Provisions**

The Board of Trustees, in its sole discretion, is empowered to change or amend any Plan provision, including, but not limited to, the Eligibility Rules or Schedule of Benefits, at any time by amendment or resolution duly executed.

#### **B. Change in Terms**

The terms of this Plan may be changed at any time except as prohibited by law. All changes in coverage will be made on a uniform basis, affecting similarly situated Participants, Employees and

Eligible Dependents equally, and will not apply to claims incurred before the amendment or termination is effective.

### **C. Amendment and Termination**

The Trustees expect and intend to continue the Plan indefinitely. However, the Trustees reserve the right, within their sole discretion, to amend or terminate this Plan at any time for any reason as they deem necessary to carry out the purposes and objectives of the Plan and Trust Agreement. If the Plan is amended or terminated, you and other active and retired members may not receive benefits as described in this document. You may be entitled to receive different benefits, or benefits under different conditions. If any modification or change to the Plan is a material reduction in covered services or benefits provided under the Plan, you and other active and retired members will be furnished with a summary of such modification or change no later than sixty (60) days after the adoption of the modification or change.

It is also possible that you will lose all benefit coverage. Loss of coverage may happen at any time, even after you retire, if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under this Plan.

### **D. Authority to Interpret Plan**

The Board of Trustees has complete authority and sole discretion to construe and interpret the provisions of the Plan and the Trust Agreement, and any ambiguity regarding whether coverage is permitted shall be construed against coverage. The Board of Trustees has the authority to decide all questions of eligibility and all questions regarding the amount and payment of any benefits provided by the Plan within the Plan's terms, as interpreted by the Trustees, in their sole discretion. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties. No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor or Internal Revenue Service regulation, ruling, release or proposed regulation or other which affects or could affect the terms of this Plan, and this Plan shall be deemed to be amended to such extent necessary to resolve any such conflict.

### **E. Legal Actions**

No actions at law or in equity shall be brought to recover any benefits provided under this Plan prior to the expiration of sixty (60) days after written proof of loss has been furnished, nor shall any such action be brought after the expiration of two (2) years after the time written proof of loss is required to be furnished.

### **F. Right to Receive and Release Necessary Information**

To determine the applicability of and to implement the terms of this provision or any provision of similar purpose in any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person

any information with respect to any person which the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Upon the request of the Trustees, you or your Dependent may be required, as a condition to continue eligibility under this Plan to apply for Social Security Benefits, Medicare and Medicaid or the program then in effect. You or your dependent may also be required as a condition to continue eligibility under this Plan to sign any authorizations or releases provided by the Trustees, as the Trustees deem necessary, enabling the Trustees to obtain information from the Participant or Dependent and appropriate government agencies pertaining to their claim for Social Security Benefits, Medicare and Medicaid benefits.

#### **G. Right of Recovery**

Whenever payments have been made by the Trust Fund with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Trust Fund shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Trust Fund shall determine: Any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations. The Trustees reserve the right to reduce or withhold future benefit payments under the Plan in order to correct a prior payment to any Participant, Employee and/or Dependent.

#### **H. Nondiscrimination Rights**

The Plan shall not discriminate against you or your dependents based on health status in eligibility, enrollment or premium contributions in accordance with federal law. However, the Trustees shall have the right to require you or your Dependent to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process a claim.

#### **I. Prohibited Discrimination**

##### **(1) Eligibility to Enroll**

- (i) In General. Subject to (ii) below, the Plan may not establish rules for eligibility (including continued eligibility) of any Participant to enroll under the terms of the Plan based on any of the following factors in relation to the Participant or the Eligible Dependent of the Participant: (a) health status; (b) medical condition (including both physical and mental illnesses); (c) claims experience; (d) receipt of health care; (e) medical history; (f) genetic information; (g) evidence of insurability (including conditions arising out of acts of domestic violence); or (h) disability.
- (ii) No Application to Benefits or Exclusions. To the extent consistent with the pre-existing condition exclusion provisions, (i) above shall not be construed:

- (a) to require the Plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such Plan; or
- (b) to prevent the Plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated Participants or Eligible Dependents enrolled in the Plan.
- (iii) Construction. For purposes of (i) above, rules for eligibility to enroll under the Plan include rules defining any applicable waiting periods for such enrollment.

(2) Premium Contributions

- (i) In General. The Plan may not require any Participant or Eligible Dependent (as a condition of enrollment or continued enrollment under the Plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated Participant or Eligible Dependent enrolled in the Plan on the basis of any factor described in Section 1 above.
- (ii) Construction. Nothing in Section 1 above shall be construed to restrict the amount that an Employer may be charged for coverage under the Plan; or to prevent the Plan from establishing premium discounts or rebates or modifying otherwise applicable co-payments or deductibles in return for adherence to programs of health promotion and disease prevention.

**J. Guaranteed Renewability**

This Plan may not deny an Employer continued access to the same or different coverage under the Plan, other than:

- (1) for nonpayment of contributions; or
- (2) for fraud or other intentional misrepresentation of material fact by the Employer; or
- (3) for noncompliance with material Plan provisions; or
- (4) because the Plan is ceasing to offer any coverage in a geographic area; or
- (5) in the event the Plan offers benefits through a network plan, because there is no longer any individual enrolled through the Employer who lives, resides, or works in the service area of the network plan and the network plan applies this paragraph uniformly without regard to the claims experience of Employers or a factor described in Section I(1) in relation to such Participants or their Eligible Dependents; or

- (6) for failure to meet the terms of an applicable Collective Bargaining Agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the Plan, or to employ Employees covered by such an agreement.

**K. Employment Rights**

The establishment of this Plan shall not be construed as conferring any legal rights upon any Employee or any other person for continuation of employment, nor shall it interfere with the rights of any Employer to discharge any Employee and/or treat him or her without regard to the effect which such treatment might have upon him or her as a Participant in this Plan.

**L. Medical Examination**

No medical examination shall be required of any person in order to obtain coverage for benefits initially. However, the Trustees shall have the right to require any Eligible Employee or Eligible Dependent whose Accident, Injury or Illness is the basis of a claim to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process the claims.

**M. Trustee Rights**

The Trustees shall have the exclusive right and sole discretion to make any finding of fact necessary or appropriate for any purpose under the Plan including, but not limited to, the determination of eligibility for and the amount of any benefit payable under the Plan. The Trustees shall have the exclusive right and sole discretion to interpret the terms and provisions of the Plan and to determine any and all questions arising under the Plan in connection with administration thereof, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies or omissions, by general rule or particular decision. The Trustees shall make or cause to be made by engaging individuals or entities, to make all reports or other filing necessary to meet the reporting and disclosure requirements of the Act. All decisions made by the Trustees, any action taken by them in respect of the Plan or the Trust Agreement, shall be conclusive and binding on all persons, and shall be given the maximum possible deference allowed by law.

**N. Payment of Benefits**

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, any Employer, or the Trustees. The Trustees, the Employers and Union shall not be held liable for any benefits or contracts, except as provided in the Agreement between the Employers and the Union.

**O. Delinquent Contributions**

In order to protect the interests of the Participants and beneficiaries of the Plan, the Trustees reserve the right to promulgate rules and regulations denying further participation in the Plan by Employees

where Employer contributions on behalf of one or more Employees have been in arrears for a specified number of hours or weeks of service, as determined by the Trustees in their sole discretion, and/or to delay the payment of claims arising on such individual until contributions are received by the Trust Fund office on behalf of all Employees.

**P. Post-Mortem Benefits**

Any benefit payable under the Plan after the death of a Participant is to be paid to the Beneficiary listed on file at the Third Party Administrator's office, and otherwise to the following classes of successive preference beneficiaries then surviving: the Participant's (1) spouse, (2) lineal descendants, (3) parents, (4) siblings, and (5) executor or administrator of the Participant's estate. If any doubt exists about the right of any beneficiary to receive any amount, the Plan Administrator may retain the disputed amount until the rights to that amount are determined, without any liability for any interest on the amount, or the Plan Administrator may pay the amount to any court of appropriate jurisdiction. In either event, neither the Plan Administrator nor any Employer is under any further liability to any person.

**Q. Compliance with Claim Rules**

The Trustees reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the Plan's purposes, or who does not present a bona fide claim.

**R. Governing Laws**

This Plan shall be construed, enforced and administered and the validity determined in accordance with ERISA, as amended, the Internal Revenue Code of 1986, as amended, and, to the extent not preempted by federal law, the law of the State of Ohio.

**S. Official Plan Records**

You may submit whatever records and evidence you believe are appropriate in support of your claim for benefits. However, the Trustees shall rely upon the records of the Plan ("Official Plan Records") in determining your eligibility for benefits and, if you are eligible, the amount of your benefits. In the event of a discrepancy between the Official Plan Records and the records or other evidence supporting the claim asserted by you or your beneficiary, the Trustees shall rely upon the Official Plan Records unless shown to their satisfaction that the additional or other records/evidence you submitted are valid and that the Trustees should rely upon those records/evidence. The burden of proving a claim for benefits which differs from the Official Plan Records shall be upon you or your beneficiary.

**XX. SPECIAL NOTICE REGARDING MASTECTOMY COVERAGE**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall, at a minimum, provide for:

- (1) Reconstruction of the breast on which the mastectomy was performed;
- (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (3) Prostheses and physical complications for all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and coinsurance.

If you have any questions regarding these federal requirements, please contact the Plan Administrator.

#### **XXI. REQUIREMENTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996**

Maternity and obstetrical benefits are available only to you and your Spouse (while you are eligible). The Plan also covers complications arising during pregnancy that result in Surgery or treatment in a hospital.

Under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, this law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have any questions regarding these requirements under federal law, please contact the Plan Administrator.

#### **XXII. THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)**

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), employees and dependents who are eligible for coverage but who are not enrolled for coverage may exercise special enrollment rights and enroll in the plan if the Employee or dependent:

- A. Loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or
- B. Loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or

- C. Becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arises and the Employee or dependent wishes to take advantage of these special enrollment rights, the employee or dependent must request to enroll for coverage within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan, or (2) the Employee or dependent Child is determined eligible for state premium assistance.

If you believe you are eligible for Special Enrollment under this provision, you must contract the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for Special Enrollment right must be made within 60 days of an event described above that occurs.

### **XXIII. STATEMENT OF ERISA RIGHTS**

As a Participant in the Insulators Local 84 Health Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan Participants are entitled to the following:

#### **A. Receive Information about Your Plan and Benefits**

You may examine, without charge, at the Plan Sponsor's office and at other locations (certain worksites and the Union Hall), all documents governing the plan, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Sponsor, copies of all documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Sponsor may make a reasonable charge for the copies.

You may receive a summary of the Plan's Annual Financial Report. The Plan Sponsor is required by law to furnish each Participant with a copy of this summary annual report.

#### **B. Continue Group Health Coverage**

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan and the rules governing your COBRA continuation coverage rights.

You may qualify for reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You

should be provided a certificate of creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **C. Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan Participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **D. Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator’s control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **E. Assistance with Your Questions**

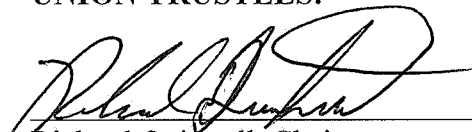
If you have any questions about your Plan, you should contact the Third Party Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.

20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The nearest Area Office of the Employee Benefits Security Administration is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Fort Wright, Kentucky 41011 at (606) 578-4680.

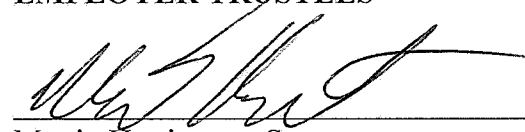
**THE BOARD OF TRUSTEES**

**IN WITNESS WHEREOF**, this instrument has been executed by the Board of Trustees on the Insulators Local 84 Health Care Plan this 2<sup>nd</sup> day of October 2018.

**ON BEHALF OF  
UNION TRUSTEES:**

  
\_\_\_\_\_  
Richard Quintrell, Chairman

**ON BEHALF OF  
EMPLOYER TRUSTEES**

  
\_\_\_\_\_  
Martin Harrington, Secretary